OBSTETRICS & GYNECOLOGY

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- Comments from the reviewers and editors (email to author requesting revisions)
- Response from the author (cover letter submitted with revised manuscript)*

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

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

Date: Nov 13, 2020
To: "Makeba Williams" mwilliams28@wisc.edu
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-20-2867

RE: Manuscript Number ONG-20-2867

Immediate postpartum salpingectomy compared to standard tubal ligation following vaginal delivery

Dear Dr. Williams:

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 Dec 04, 2020, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: Thank you for your excellent submission to Obstetrics and Gynecology. I thoroughly enjoyed reading your manuscript titled "Immediate postpartum salpingectomy compared to standard tubal ligation following vaginal delivery." You clearly explain how efforts at ovarian cancer prevention have evolved in recent years, and how postpartum sterilization is another, yet rarely studied, opportunity for ovarian cancer prophylaxis. You clearly and efficiently discuss how you completed your retrospective cohort study, and I believe your methods, inclusion and exclusion criteria, and statistical analysis were highly appropriate for this study. Specifically, I was delighted to see your a priori Power calculations, and that your study had enough cases to fulfill those requirements. While your calculations did not account for the study's secondary outcomes, I believe that doing so would have been beyond the scope of this study, and the data from this study can be used for future studies assessing those secondary outcomes. I also believe that analyzing blood loss as a dichotomous variable was ingenious and allowed you to use logistic regression to assess for confounding factors, however I am curious as to how you settled on 5 mL as the cut off for estimated blood loss. Most importantly, your study yielded solid results that you clearly explain. You also explain which particular surgical practices may account for your findings, and how these practices may lead to results not found in previous studies. The only question I had in reading your manuscript is how you choose 5 mL as the cut off for estimated blood loss, however I don't believe explaining this further will improve this manuscript's impact.

Reviewer #2: Given the cost of the Ligasure instrument and use with several GYN procedures in your institution, can you determine the relative cost differntial per procedure in the postpartum bilateral salpingectomy vs. the BTL, including equipment cost and intra-operative maintenance (e.g., cleaning, storage)?

Did the BTL group with prior cesarean document frequency of extensive adhesions?

The frequency of depression history in both groups was substantial compared to postpartum depression recorded in the study. While not a main secondary evaluative variable, was this considered within normal ranges fro the population related to the cohort?

In table 1, GBS is mentioned in the legend, but not within the variables in the table.

Table 2 is difficult to interpret in portrait page form; recommend changing font or converting to landscape page format.

You discuss that opioid and antibiotic use differential may have reflected on time of onset of use of Ligasure in the study.

Perhaps a table or figure might clarify wh use changed over the cohort study period.

Do you think that Ligasure or similar instruments should be promoted

Reviewer #3: This is a retrospective cohort study comparing salpingectomy to standard tubal interruption for postpartum sterilization after vaginal delivery.

1. Precis/Abstract/Conclusions: Is 3 minutes a big enough difference to say it is "shorter"? I think the message should be that it doesn't take any longer on average when you are using Ligasure. The use of Ligasure should be added to the Precis and Abstract Conclusions e.g. bilateral salpingectomy can be completed with equivalent operative times as bilateral tubal ligation when electrocautery (Ligasure) is used. I would exclude the 7 cases done with suture ligation or analyze them separately.

2. Methods: Why were women less than 18 excluded? How well was family history actually documented in the chart?

3. Methods: Please add in the methods how the salpingectomy was done.

4. Methods: Dichotomizing EBL to 5 mL or less or greater than 5 mL is not helpful. Please report the mean EBL and compare them.

5. Results: Please report how many procedures were done with each technique by year of the study. I would also control for year of the study and is there a reason a multivariable analysis was not performed for the primary outcome? How many different surgeons were included in the study?

6. Discussion: Please temper conclusions as above. I agree with the concern over the cost of the Ligasure for the hospital in terms of reimbursement for the procedure. I agree with the timing of the cohort affecting the difference in opioid prescribing so I am not sure that should be a real outcome.

7. Table 1: It is unclear to me if obstetric history includes the most recent delivery prior to the sterilization.

STATISTICAL EDITOR COMMENTS:

The Statistical Editor makes the following points that need to be addressed:

lines 146-150: If a continuous data distribution was normal, then should summarize as mean ± SD. If is was non-normal, then should summarize as median(IQR or range) and test non=parametrically, not by applying student's t test.

Table 1: Need units for age. Operative times are often skewed, ie, not conforming to a normal distribution. Need to test the distributions and if non-normal, then use a non-parametric test, not student's t test. Also, is the difference in mean times of 3 minutes clinically important, or just having statistical significance (assuming the aforementioned issue re: parametric vs non-parametric testing is resolved)?

Fortunately, the rates of post-op transfusion and various post op complications were low, so there is little stats power to generalize the various NS findings.

EDITOR COMMENTS:

1. Please temper your Abstract-Conclusion and Discussion ("average shorter operative time"). A three minute time difference is minimal.

2. 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.

3. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA). When you are ready to revise your manuscript, you will be prompted in Editorial Manager (EM) to click on "Revise Submission." Doing so will launch the resubmission process, and you will be walked through the various questions that comprise the eCTA. Each of your coauthors will receive an email from the system requesting that they review and electronically sign the eCTA.

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

4. 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.

5. Please submit a completed STROBE checklist.

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.

6. 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.

7. 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.

8. 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).

9. 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. Please provide a word count.

10. 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.

11. 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.

12. 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.

13. 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%").

14. Line 213-215: Your manuscript contains a priority claim. 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 it is not based on a systematic search but only on your level of awareness, it is not a claim we permit.

15. 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.

16. 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).

17. 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.

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.

18. 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 Dec 04, 2020, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

Dwight J. Rouse, MD, MSPH

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

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Dwight J. Rouse, MD, MSPH
The Green Journal Obstetrics & Gynecology

November 27, 2020

Dear Dr. Rouse,

Subject: Manuscript Number **ONG-20-2867**

Thank you for your email and the opportunity to revise our manuscript, "**Immediate postpartum salpingectomy compared to standard tubal ligation following vaginal delivery ".** We appreciate the reviewers' additional comments. After thoughtful consideration of each of these comments, we have made additional manuscript revisions.

We have included the reviewer comments below with our point-by-point responses italicized. We've included line numbers to indicate where we addressed each concern, and described the changes we have made. The revised manuscript has been submitted through Editorial Manager for Obstetrics and Gynecology.

We hope the revised manuscript is better suited for publication in Obstetrics and Gynecology. We are happy to consider further revisions, and we thank you for the interest in this manuscript.

Sincerely,

Makeba Williams, M.D., FACOG, NCMP
Clinical Associate Professor
Director, Division of Academic Specialists in Obstetrics and Gynecology
Department of OB/GYN
University of Wisconsin School of Medicine and Public Health

[redacted] [redacted] [redacted]

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REVIEWER COMMENTS:

Reviewer #1: Thank you for your excellent submission to Obstetrics and Gynecology. I thoroughly enjoyed reading your manuscript titled "Immediate postpartum salpingectomy compared to standard tubal ligation following vaginal delivery." You clearly explain how efforts at ovarian cancer prevention have evolved in recent years, and how postpartum sterilization is another, yet rarely studied, opportunity for ovarian cancer prophylaxis. You clearly and efficiently discuss how you completed your retrospective cohort study, and I believe your methods, inclusion and exclusion criteria, and statistical analysis were highly appropriate for this study. Specifically, I was delighted to see your a priori Power calculations, and that your study had enough cases to fulfill those requirements. While your calculations did not account for the study's secondary outcomes, I believe that doing so would have been beyond the scope of this study, and the data from this study can be used for future studies assessing those secondary outcomes. I also believe that analyzing blood loss as a dichotomous variable was ingenious and allowed you to use logistic regression to assess for confounding factors, however I am curious as to how you settled on 5 mL as the cut off for estimated blood loss. Most importantly, your study yielded solid results that you clearly explain. You also explain which particular surgical practices may account for your findings, and how these practices may lead to results not found in previous studies. The only question I had in reading your manuscript is how you choose 5 mL as the cut off for estimated blood loss, however I don't believe explaining this further will improve this manuscript's impact.

Thank you very much for your comments. Regarding estimated blood loss, the practice at our institution is to report blood loss as <5mL for tubal sterilization procedures (in lieu of 1 mL, 2 mL etc.) or greater on a numeric scale. In our cohort EBL ranged from < 5 mL to 2 L for one patient experiencing postoperative hemorrhage. In comparing mean EBL for this procedure, this would have grossly over estimated blood loss for the bilateral tubal ligation cohort, hence our decision to preserve dichotomized values congruent with the institutional practice.

Reviewer #2:
1. Given the cost of the Ligasure instrument and use with several GYN procedures in your institution, can you determine the relative cost differential per procedure in the postpartum bilateral salpingectomy vs. the BTL, including equipment cost and intra-operative maintenance (e.g., cleaning, storage)?

We appreciate your comments. Costs associated with the Ligasure device range from $954.26-$1097.40 at our institution depending on the type and size of Ligasure device used. As a single use devise, there are no additional cleaning and storage costs. Other indirect costs are unknown at this time. We are in the process of planning a cost effectiveness analysis to evaluate the use of the Ligasure device for salpingectomy in the immediate postpartum period at our institution.

2. Did the BTL group with prior cesarean document frequency of extensive adhesions?

Presence of adhesions and severity of adhesive disease was not documented.

3. The frequency of depression history in both groups was substantial compared to postpartum depression recorded in the study. While not a main secondary evaluative variable, was this considered within normal ranges for the population related to the cohort?

Our rate of depression was 28.3% for the BTL group and 29.4% for the salpingectomy group. Postpartum depression for the BTL group was 4.4% and for the salpingectomy group was 5.4%. The incidence of postpartum depression estimated in the literature is ~10% and various definitions include depressive episodes diagnosed during the antenatal or peripartum period. We categorized all episodes of depression diagnosed in the antenatal period as depression while episodes of postpartum depression were characterized as being diagnosed within 6 weeks postpartum. Similarly, as the incidence of postpartum depression is described up to 12 months postpartum, we anticipate our findings would under represent postpartum depression as we only recorded data out to 6 weeks postpartum.

4. In table 1, GBS is mentioned in the legend, but not within the variables in the table.

GBS is now removed from the revised table.

5. Table 2 is difficult to interpret in portrait page form; recommend changing font or converting to landscape page format.

We have revised Table 2 and altered the font for clarity.

6. You discuss that opioid and antibiotic use differential may have reflected on time of onset of use of Ligasure in the study. Perhaps a table or figure might clarify why use changed over the cohort study period.

Thank you for your suggestion. While we hypothesize that opioid prescribing and use of antibiotic prophylaxis evolved over the study period, use of the Ligasure remained consistent within the salpingectomy cohort. We believe the supplementation of this finding in the form of a figure or table would not significantly contribute to understanding of the manuscript. However, we are willing to further consider this recommendation.

7. Do you think that Ligasure or similar instruments should be promoted

We do not necessarily promote the use of Ligasure or electrocautery devices for tubal sterilization, however our data demonstrate that the Ligasure may be a reasonable option for surgeons to consider given comparable operative time and surgical outcomes.

Reviewer #3:
1. Precis/Abstract/Conclusions: Is 3 minutes a big enough difference to say it is "shorter"? I think the message should be that it doesn't take any longer on average when you are using Ligasure. The use of Ligasure should be added to the Precis and Abstract Conclusions e.g. bilateral salpingectomy can be completed with equivalent operative times as bilateral tubal ligation when electrocautery (Ligasure) is used. I would exclude the 7 cases done with suture ligation or analyze them separately.

Thank you for your comments and questions. We have made the suggested changes to the precis and abstract. These changes may be found on lines 36-37, 80-81 and 87-88 respectively.

With regard to the 7 cases performed by suture ligation, we performed a multivariable analysis including OR time, year of procedure, BMI, history of cesarean section, history of sexually transmitted infections, and history of appendectomy and have included details of this analysis on lines 209-214. When excluding these 7 cases, we observe no significant differences in operative times between the salpingectomy or BTL cohorts (Lines 211-214). We elected to include these 7 patients in our analysis as our objective was to evaluate salpingectomy compared to bilateral tubal ligation by any method. We have retained these 7 patients in the cohort per our original methods as their inclusion does not significantly affect the result of our multivariant analysis.

2. Methods: Why were women less than 18 excluded? How well was family history actually documented in the chart?

Patients less than 18 years of age were excluded pursuant to the institution's IRB approve for this study which excludes the review of medical records of patients less than 18 years of age. Family history within the electronic medical record was reviewed and updated during OB intake at new OB visits and upon presentation to the hospital for labor admission consistent with our practice at our institution.

3. Methods: Please add in the methods how the salpingectomy was done.

The description of salpingectomy procedure has been added to the methods section and can be found in lines 131-146.

4. Methods: Dichotomizing EBL to 5 mL or less or greater than 5 mL is not helpful. Please report the mean EBL and compare them.

We acknowledge the limitations of a dichotomous metric for EBL in our study. As noted in our response to Reviewer#1, the decision to use treat EBL as a dichotomous variable stem from the non-normally distributed data with the majority of procedures having minimal blood loss. Were we to use means, outliers such as patients experiencing intraoperative or postoperative hemorrhage would skew this metric away from the true distribution. Many operative reports documented <5mL EBL leading to our decision to treat this variable as dichotomous. As this is a secondary variable and hypothesis generating, we found it appropriate.

5. Results: Please report how many procedures were done with each technique by year of the study. I would also control for year of the study and is there a reason a multivariable analysis was not performed for the primary outcome? How many different surgeons were included in the study?
Please see our response to Reviewer #3, point #1 for comments in regards to multivariable analysis.

We included year in the model as a dichotomous variable (before 2014 vs. 2014-2019). As there were no bilateral salpingectomies observed prior to 2014, we feel it would be inappropriate to model year as an interval measure.

We performed a multivariable analysis including OR time, year of procedure, BMI, history of cesarean section, history of sexually transmitted infections, and history of appendectomy and have included

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details of this analysis on lines 209-214. We have included a discussion of a multivariable linear regression model for operative time. In addition, given concerns about the skewed distribution of procedure time, we conducted a linear regression with a log transformation of procedure time and as well as a quantile regression. Results were similar in terms of magnitude and significance to results from the OLS regression, so for ease of interpretation, we discuss the OLS regression in the text. For space reasons, we do not include a table for results, as the difference in operative times remained small and non-significant.

Eighteen attending surgeons were identified over the course of the study period; obstetrics and gynecology residents assist with sterilizations at our institution.

6. Discussion: Please temper conclusions as above. I agree with the concern over the cost of the Ligasure for the hospital in terms of reimbursement for the procedure. I agree with the timing of the cohort affecting the difference in opioid prescribing so I am not sure that should be a real outcome.
Revisions have been made and are found on lines 216-218.

7. Table 1: It is unclear to me if obstetric history includes the most recent delivery prior to the sterilization.
We apologize for the lack of clarity. Table 1 has been updated.

STATISTICAL EDITOR COMMENTS:

1. lines 146-150: If a continuous data distribution was normal, then should summarize as mean ± SD. If is was non-normal, then should summarize as median(IQR or range) and test non=parametrically, not by applying student's t test.

Thank you for your feedback. This has been revised and clarified on lines 167-172.

2. Table 1: Need units for age. Operative times are often skewed, ie, not conforming to a normal distribution. Need to test the distributions and if non-normal, then use a non-parametric test, not student's t test. Also, is the difference in mean times of 3 minutes clinically important, or just having statistical significance (assuming the aforementioned issue re: parametric vs non-parametric testing is resolved)?

We have added units for age Table 1.

Tests for normality for operative time and length of stay (Shapiro-Wilk test, overall test of skewness and kurtosis) led to a rejection of the normality hypothesis. Table 2 has been edited to remove mean times and retain the median and inter-quartile range for operative time and length of stay. The sample size in each group is sufficiently large that the central limit theorem holds true and the distribution of the sample means will be approximately normally distributed, so that the t-test is appropriate. Nonetheless, we have changed the test statistic to the Wilcoxon rank-sum test (Mann-Whitney U test) for these two outcomes in Table 2.

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EDITOR COMMENTS:

1. Please temper your Abstract-Conclusion and Discussion ("average shorter operative time"). A three minute time difference is minimal.

Thank you for your comments. We have revised these sections of the manuscript.

2. 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.

We opt-in. Yes, please publish my point-by-point response letter.

3. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA). When you are ready to revise your manuscript, you will be prompted in Editorial Manager (EM) to click on "Revise Submission." Doing so will launch the resubmission process, and you will be walked through the various questions that comprise the eCTA. Each of your coauthors will receive an email from the system requesting that they review and electronically sign the eCTA.

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

We have confirmed that all disclosures are correct on the manuscript's title page.

4. 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.

This has been added to the manuscript and Table 1.

[redacted]

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5. Please submit a completed STROBE checklist.

Completed STROBE checklist is attached separately.

6. 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.
We attest to adherence to the reVITALize definitions.

7. 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.

The current abstract word count is 283. The current manuscript word count is 2789.

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

* All financial support of the study must be acknowledged.
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