OBSTETRICS & GYNECOLOGY

NOTICE: This document contains correspondence generated during peer review and subsequent revisions but before transmittal to production for composition and copyediting:

- 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: Sep 24, 2021
To: "Paula Jaye Doyle" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-21-1768

RE: Manuscript Number ONG-21-1768

Surgical removal of anti-incontinence mesh in women undergoing surgery for presumed mesh related complications: A systematic review and meta-analysis of outcomes

Dear Dr. Doyle:

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).

Please be sure to address the Editor comments (see "EDITOR COMMENTS" below) in your point-by-point response.

Your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Oct 15, 2021, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1:

Title:
Surgical removal of anti-incontinence mesh in women undergoing surgery for presumed mesh related complications: A systematic review and meta-analysis of outcomes

Introduction Summary:
Although being considered gold standard, using suburethral alloplastic slings might lead to the necessity to transect or remove as sling in order to cure adverse effects such as pain, erosion, overactive bladder syndrome, injuries and others. It is important to review the literature about outcome variables regarding this problem.

Novelty:
given

Methodology:
systematic review

Presentation
very good, classification somehow confusing

Hypothesis:
n/a

Null hypothesis:
n/a

Population:
n/a

Study Design:
systematic review

Inclusion Criteria:
studies with mesh removal for any reason

Exclusion Criteria:
n/a

Primary outcome:
LUTS
Erosion
Pain
Bladder outlet obstruction
SUI

Data Collected:
See above

Results:
45 eligible studies
Partial mesh removal leads to lower rates of recurrent SUI
Similarly effective to treat pain, boo, erosion, LUTS

Conclusions:
Post-operative stress incontinence may be lower with partial versus total mesh removal
Other outcomes similar

Questions/comments for the Authors:
The systematic review "Surgical removal of anti-incontinence mesh in women undergoing surgery for presumed mesh related complications: A systematic review and meta-analysis of outcomes" is an important, excellent manuscript that is urgently needed in the field of urogynecology. I would like to congratulate the authors for their hard work and I really would like to see this great work published.

However, I have some thoughts and comments that came into my mind going through your manuscript:

1. A lot of confusion and misunderstanding in the FDA-warnings regarding vaginal mesh and the effects of these warnings on SUI treatment using alloplastic slings comes from an ongoing mixture of using the terms "mesh". Don't you think it would be helpful to clearly distinguish between those two entities. I would recommend to use the term "mesh" for vaginal or abdominal/endoscopic prolapse repair such as sacrocolpopexy or vaginal mesh for prolapse repair.
According to the "Joint position statement on the management of mesh-related complications for the FPMRS specialist" (your citation no. 4) the term "retropubic MUS" or "transobturator MUS" has been defined as a proper term. So, "alloplastic retropubic MUS" would be a good way to reduce confusion. I would not call a TVT an "anti-incontinence mesh". Maybe changing the title would be helpful.

2. Your classification of sling removal is somehow confusing:
Line 58: "Our intervention of interest was total mesh sling removal, which was defined as removal of the entire vaginal portion of the sling, with or without removal of the retropubic or obturator arms, through vaginal and/or abdominal approaches."

So, it is clearly a different approach to entirely remove a sling, i.e. there is no alloplastic material left, vs. to remove a sling vaginally as far as possible, i.e. the entrance of the sling into the urogenital diaphragm. In the first case, laparotomy is needed (or the exploration of the obturator fossa), in the second one the procedure can be performed vaginally only. So, why did you put these two entities in one?

your other classifications are:
partial mid-urethral mesh-excision
transection of the sling
early mobilization

I would like to recommend the following classification in following citation no. 4:
1. Complete vaginal and extravaginal mesh excision (no alloplastic material is left)
2. Complete vaginal mesh excision (only retropubic alloplastic material or outside the obturator membrane is left)
3. Extravaginal mesh excision (retropubic or transobturator parts are removed)
4. Partial vaginal mesh excision or sling removal
   a. Suburethral mesh excision (The term mid-urethral is used to clarify the fact that the sling is not placed distally or proximally in relation to the bladder neck)
   b. Lateral partial vaginal mesh excision(e.g. only one side of the vaginal part of the sling has to be removed due to pain

or erosion)
5. Sling transection (midline or laterally, this needs to be described)
6. Early sling mobilisation

As you have mentioned in your discussion, mesh removal is always a highly individualized procedure that needs to be explained very detailed to the patient. This needs to be emphasized in your discussion and recommendation. The fact that you could not find any significant difference other than recurrent SUI in different approaches to mesh removal, might be due to the individualized and heterogenous techniques.

Reviewer #2:

Comments to the author:

The authors present a clinically relevant systematic review and meta analysis of surgical outcomes related to vaginal anti incontinence mesh removal due to presumed complications. All studies included were retrospective. Specific comparisons were made between partial vs. complete removal with a focus on outcomes of recurrent stress incontinence and pain. The findings suggested improved continence with partial vs. complete removal. Other outcomes including postoperative pain were similar.

Abstract:
Line 18 Why did you state OR<1 and then give the actual OR .46. This seems redundant.

Introduction:
Line 29 I would expand upon what comparative studies you are making to more invasive procedures. MMK, Kelly plication etc. with references.
Line 56-57 Clarify the a priori criteria. Were these isolated to patients who only had a midurethral sling or did they have other procedures like cystocele repair without mesh or apical support procedures. These may impact healing and potential outcomes being studied.
Did you include all types of slings like TVT, TOT and the single incision min sling?
Line 61-62 Clarify the definition of partial. Including transection and early mobilization by any means seem to be completely different and perhaps should not be included. If someone has short term retention and you are able to improve their symptoms by aggressive urethral dilation under anesthesia this should not be conflated with transection or partial excision.
Line 76-77 Who was the third team member who resolved full text review? Was it the lead author?

Results:
Line 114-116 Of the total 45 reviews only 10 ultimately included complete removal making the comparisons weighted towards partial removal.
Line 120-121 The range of times from placement to removal is quit large. Some of the outcomes of interest are directly related to time even without complications.
Tables and Figures are easy to read and stand alone.

Discussion:
Line 293-297 The fair to poor quality of the studies may make the sweeping conclusions made here about partial vs complete removal inappropriate. A patient with pain and erosion of mesh is not the same as someone who has postoperative urinary retention. The later may benefit from mobilization alone. If these are included in the partial removal cohort it seems likely they would have lower SUI. I am not sure if there are enough numbers for a sub-analysis but comparing apples to apples for preop indication may be more clinically relevant.
The remainder of the discussion address many of the comments and the recommendations are correctly identified as weak.

Reviewer #3:

Lines 16-18, 242-254, Fig 2: Only one of the 3 studies demonstrated a statistically significant difference in SUI for partial vs total mesh removal and the three studies differed in duration of follow-up. Only the study with the shortest follow-up demonstrated a significant difference, favoring the partial removal. Seems imprudent to conclusively find a significant difference. A better study design would have been to compare the three studies in terms of hazard rate ratios, which would have accounted for varying times. Also, there is no adjustment for any baseline differences among the three groups. Therefore, seems imprudent to conclusively find a significant difference.

lines 18-20, Table 2: Should compare the duration of follow-up for the two groups. Again, there is no adjustment for differences in baseline characteristics or variable follow-up times for the two groups. So, the comparison of unadjusted rates of SUI may yield an inaccurate conclusion.

Fig 2: Should include a column of weights attributed to the three studies.

Table 2: Should include a column of duration of follow-up, formatted as median(range or IQR) for each study and then comparing those durations. Also, should include a column attributing the weight given to each study in the calculation of overall prevalence for each cohort (partial vs total).

EDITOR COMMENTS:
Please in your revision delete the meta-analysis and simply format this as a systematic review.

EDITORIAL OFFICE COMMENTS:

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

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

2. When you submit your revised manuscript, please make the following edits to ensure your submission contains the required information that was previously omitted for the initial double-blind peer review:
* Include your title page information in the main manuscript file. The title page should appear as the first page of the document. Add any previously omitted Acknowledgements (ie, meeting presentations, preprint DOIs, assistance from non-byline authors).
* Funding information (ie, grant numbers or industry support statements) should be disclosed on the title page and in the body text. For industry-sponsored studies, the Role of the Funding Source section should be included in the body text of the manuscript.
* Include clinical trial registration numbers, PROSPERO registration numbers, or URLs at the end of the abstract (if applicable).
* Name the IRB or Ethics Committee institution in the Methods section (if applicable).
* Add any information about the specific location of the study (ie, city, state, or country), if necessary for context.

3. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA), which must be completed by all authors. When you uploaded your manuscript, each co-author received an email with the subject, "Please verify your authorship for a submission to Obstetrics & Gynecology." Please check with your coauthors to confirm that they received and completed this form, and that the disclosures listed in their eCTA are included on the manuscript's title page.

4. Our journal requires that all evidence-based research submissions be accompanied by a transparency declaration statement from the manuscript's lead author. The statement is as follows: "The lead author* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained." *The manuscript's guarantor.

If you are the lead author, please include this statement in your cover letter. If the lead author is a different person, please ask him/her to submit the signed transparency declaration to you. This document may be uploaded with your submission in Editorial Manager.

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: Review articles should not exceed 6,250 words. Stated word limits include the title page, précis, abstract, text, tables, boxes, and figure legends, 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. Provide a short title of no more than 45 characters (40 characters for case reports), including spaces, for use as a running foot.

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; 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.

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. 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. 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.

14. 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.

15. 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 references you are citing are still current and available. Check the Clinical Guidance page at https://www.acog.org/clinical (click on "Clinical Guidance" at the top). If the reference is still available on the site and isn't listed as "Withdrawn," it's still a current document.

If the reference you are citing has been updated and 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.

16. When you submit your revision, art saved in a digital format should accompany it. If your figure was created in Microsoft Word, Microsoft Excel, or Microsoft PowerPoint formats, please submit your original source file. Image files should not be copied and pasted into Microsoft Word or Microsoft PowerPoint.

When you submit your revision, art saved in a digital format should accompany it. Please upload each figure as a separate file to Editorial Manager (do not embed the figure in your manuscript file).

If the figures were created using a statistical program (eg, STATA, SPSS, SAS), please submit PDF or EPS files generated directly from the statistical program.

Figures should be saved as high-resolution TIFF files. The minimum requirements for resolution are 300 dpi for color or black and white photographs, and 600 dpi for images containing a photograph with text labeling or thin lines.

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

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.

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

If you choose open access, you will receive an Open Access Publication Charge letter from the Journal's Publisher, Wolters Kluwer, and instructions on how to submit any open access charges. The email will be from publicationservices@copyright.com with the subject line, "Please Submit Your Open Access Article Publication Charge(s)." Please complete payment of the Open Access charges within 48 hours of receipt.

***

If you choose to revise your manuscript, please submit your revision through Editorial Manager at http://ong.editorialmanager.com. Your manuscript should be uploaded as a Microsoft Word document. 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 Oct 15, 2021, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,
Dwight J. Rouse, MD
Associate Editor, Obstetrics

2020 IMPACT FACTOR: 7.661
2020 IMPACT FACTOR RANKING: 3rd out of 83 ob/gyn journals

Manuscript Number ONG-21-1768

Dear Editor and Reviewers,

Thank you for reviewing our systematic review manuscript on the total versus partial mesh removal of previously placed anti-incontinence slings in women. We intend to submit this Review only to the Obstetrics & Gynecology Journal. Our team has been transparent with conflicts, methods, data sourcing and synthesis of the results. The Systematic Review was registered with PRESPO in advance of writing the manuscript. The findings of this work were presented at the Society of Gynecologic Surgeons (SGS) in July 2020. I, Paula Doyle, affirm that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.

I have an Appendix of search terms available upon request.

Word count:

Title: 504
Precis: 24
Abstract:242
Text: 4086
Legends: 121

Thank you very much for taking the time to read and review our submission. Below are our responses in **bold**.

Reviewer #1:

However, I have some thoughts and comments that came into my mind going through your manuscript:

1. A lot of confusion and misunderstanding in the FDA-warnings regarding vaginal mesh and the effects of these warnings on SUI treatment using alloplastic slings comes from an ongoing mixture of using the terms "mesh". Don't you think it would be helpful to clearly distinguish between those two entities. I would recommend to use the term "mesh" for vaginal or abdominal/endoscopic prolapse repair such as sacrocolpopexy or vaginal mesh for prolapse repair.
According to the "Joint position statement on the management of mesh-related complications for the FPMRS specialist" (your citation no. 4) the term "retropubic MUS" or "transobturator MUS" has been defined as a proper term. So, "alloplastic retropubic MUS" would be a good way to reduce confusion. I would not call a TVT an "anti-incontinence mesh". Maybe changing the title would be helpful.

<u>Response:</u> Thank you for the suggestion. The title has been changed to:

Title:
Surgical removal of midurethral slings in women undergoing surgery for presumed mesh related complications: A systematic review of outcomes

In addition, throughout the manuscript we changed 'anti-incontinence sling' to 'midurethral sling'.

2. Your classification of sling removal is somehow confusing:
Line 58: "Our intervention of interest was total mesh sling removal, which was defined as removal of the entire vaginal portion of the sling, with or without removal of the retropubic or obturator arms, through vaginal and/or abdominal approaches."

So, it is clearly a different approach to entirely remove a sling, i.e. there is no alloplastic material left, vs. to remove a sling vaginally as far as possible, i.e. the entrance of the sling into the urogenital diaphragm. In the first case, laparotomy is needed (or the exploration of the obturator fossa), in the second one the procedure can be performed vaginally only. So, why did you put these two entities in one?

your other classifications are:
partial mid-urethral mesh-excision
transection of the sling
early mobilization

I would like to recommend the following classification in following citation no. 4:
1. Complete vaginal and extravaginal mesh excision (no alloplastic material is left)
2. Complete vaginal mesh excision (only retropubic alloplastic material or outside the obturator membrane is left)
3. Extravaginal mesh excision (retropubic or transobturator parts are removed)
4. Partial vaginal mesh excision or sling removal
   a. Suburethral mesh excision (The term mid-urethral is used to clarify the fact that the sling is not placed distally or proximally in relation to the bladder neck)
   b. Lateral partial vaginal mesh excision(e.g. only one side of the vaginal part of the sling has to be removed due to pain or erosion)
5. Sling transection (midline or laterally, this needs to be described)
6. Early sling mobilisation

As you have mentioned in your discussion, mesh removal is always a highly individualized procedure that needs to be explained very detailed to the patient. This needs to be emphasized in your discussion and recommendation. The fact that you could not find any significant difference other than recurrent SUI in different approaches to mesh removal, might be due to the individualized and heterogenous techniques.

<u>Response:</u> We developed our PICO, including the definition for an intervention and comparator, prior to the publication of the "Joint position statement on the management of mesh-related complications for the FPMRS specialist". In addition, all manuscripts reviewed for this systematic review were published before the approved AUGS terms. As a result, the classification schema that is recommended can be implemented in primary studies going forward.

Reviewer #2:

Comments to the author:

The authors present a clinically relevant systematic review and meta-analysis of surgical outcomes related to vaginal anti incontinence mesh removal due to presumed complications. All studies included were retrospective. Specific comparisons were made between partial vs. complete removal with a focus on outcomes of recurrent stress incontinence and pain. The findings suggested improved continence with partial vs. complete removal. Other outcomes including postoperative pain were similar.

Abstract:
Line 18 Why did you state OR<1 and then give the actual OR .46. This seems redundant.

<u>Response:</u> Thank you for noticing this. On line 18, we have changed the OR from <1 to 0.46.

Introduction:
Line 29 I would expand upon what comparative studies you are making to more invasive procedures. MMK, Kelly plication etc. with references.

We added the specific comparison to a Burch retropubic urethropexy with reference.

Line 56-57 Clarify the a priori criteria. Were these isolated to patients who only had a midurethral sling or did they have other procedures like cystocele repair without mesh or apical support procedures. These may impact healing and potential outcomes being studied.

We added the sentence "We did not exclude studies that preformed a colporrhaphy or apical suspension in less than 25% of the subjects at the time of mesh removal."

Did you include all types of slings like TVT, TOT and the single incision min sling?

Yes.

Line 61-62 Clarify the definition of partial. Including transection and early mobilization by any means seem to be completely different and perhaps should not be included. If someone has short term retention and you are able to improve their symptoms by

aggressive urethral dilation under anesthesia this should not be conflated with transection or partial excision.

We changed "any" approach to "early mobilization through vaginal or abdominal approach.". We agree with your comment about urethral dilations. No reviewed papers included this technique and we added the sentence "No studies included urethral dilations."

Line 76-77 Who was the third team member who resolved full text review? Was it the lead author?

No. It was not always the lead author doing this review. It was either the lead, second or senior author reviewing the full text discrepancies.

Results:
Line 114-116 Of the total 45 reviews only 10 ultimately included complete removal making the comparisons weighted towards partial removal.

Correct.

Line 120-121 The range of times from placement to removal is quit large. Some of the outcomes of interest are directly related to time even without complications.
Tables and Figures are easy to read and stand alone.

Agreed. Thank you.

Discussion:
Line 293-297 The fair to poor quality of the studies may make the sweeping conclusions made here about partial vs complete removal inappropriate. A patient with pain and erosion of mesh is not the same as someone who has postoperative urinary retention. The later may benefit from mobilization alone. If these are included in the partial removal cohort it seems likely they would have lower SUI. I am not sure if there are enough numbers for a sub-analysis but comparing apples to apples for preop indication may be more clinically relevant.
The remainder of the discussion address many of the comments and the recommendations are correctly identified as weak.

We agree with your comments. There is heterogeneity in presenting symptom severity which is not objectively captured routinely.

Reviewer #3:

Lines 16-18, 242-254, Fig 2: Only one of the 3 studies demonstrated a statistically significant difference in SUI for partial vs total mesh removal and the three studies differed in duration of follow-up. Only the study with the shortest follow-up demonstrated a significant difference, favoring the partial removal. Seems imprudent to conclusively find a significant

difference. A better study design would have been to compare the three studies in terms of hazard rate ratios, which would have accounted for varying times. Also, there is no adjustment for any baseline differences among the three groups. Therefore, seems imprudent to conclusively find a significant difference.

Thank you for this evaluation. In the discussion section, we added "However, it should be noted that of the 3 comparative studies evaluating postoperative SUI, follow-up time varied and the study with the shortest follow-up time demonstrated the most significant difference." Regarding the hazard ratios, the studies did not report hazard ratios and we cannot calculate hazard ratios from the reported data.

lines 18-20, Table 2: Should compare the duration of follow-up for the two groups. Again, there is no adjustment for differences in baseline characteristics or variable follow-up times for the two groups. So, the comparison of unadjusted rates of SUI may yield an inaccurate conclusion.

Thank you. In the SUI results section, we added "It should be noted that a potential difference in subject baseline characteristics and follow-up times were not accounted".

Fig 2: Should include a column of weights attributed to the three studies.

Table 2: Should include a column of duration of follow-up, formatted as median (range or IQR) for each study and then comparing those durations. Also, should include a column attributing the weight given to each study in the calculation of overall prevalence for each cohort (partial vs total).

Thank you for this suggestion. As the journal does not state a preference for presenting/not presenting weights, we would prefer to leave as is.

EDITOR COMMENTS:
Please in your revision delete the meta-analysis and simply format this as a systematic review.

This has been done and the term 'meta-analysis' has been removed from the title.

EDITORIAL OFFICE COMMENTS:

1. The Editors of Obstetrics & Gynecology have increased 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.**

2. When you submit your revised manuscript, please make the following edits to ensure your submission contains the required information that was previously omitted for the initial double-blind peer review:

* Include your title page information in the main manuscript file. The title page should appear as the first page of the document. Add any previously omitted Acknowledgements (ie, meeting presentations, preprint DOIs, assistance from non-byline authors).
* Funding information (ie, grant numbers or industry support statements) should be disclosed on the title page and in the body text. For industry-sponsored studies, the Role of the Funding Source section should be included in the body text of the manuscript.
* Include clinical trial registration numbers, PROSPERO registration numbers, or URLs at the end of the abstract (if applicable).
* Name the IRB or Ethics Committee institution in the Methods section (if applicable).
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