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

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

Personal or nonessential information may be redacted at the editor's discretion.

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

Date: 11/18/2022
To: "Jason D. Wright" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-22-1880

RE: Manuscript Number ONG-22-1880

Trends in Inpatient Hysterectomy Rates Associated with the COVID-19 Pandemic

Dear Dr. Wright:

Thank you for sending us your work for consideration for publication in Obstetrics & Gynecology. Your manuscript has been reviewed by the Editorial Board and by special expert referees. The Editors would like to invite you to submit a revised version for further consideration.

If you wish to revise your manuscript, please read the following comments submitted by the reviewers and Editors. Each point raised requires a response, by either revising your manuscript or making a clear argument as to why no revision is needed in the cover letter.

To facilitate our review, we prefer that the cover letter you submit with your revised manuscript include each reviewer and Editor comment below, followed by your response. That is, a point-by-point response is required to each of the EDITOR COMMENTS (if applicable), REVIEWER COMMENTS, and STATISTICAL EDITOR COMMENTS (if applicable) below.

The revised manuscript should indicate the position of all changes made. Please use the "track changes" feature in your document (do not use strikethrough or underline formatting).

Your submission will be maintained in active status for 10 days from the date of this letter. If we have not heard from you by 11/28/2022, we will assume you wish to withdraw the manuscript from further consideration.

EDITOR COMMENTS:

Dear Dr. Wright and authors,
Thank you for your submission. After a thorough review process and discussion, we would like to offer the opportunity to submit this work as a research letter.

We hope you will consider this.Please do not hesitate to contact us with any questions.

Please also note the following:

* Help us reduce the number of queries we add to your manuscript after it is revised by reading the Revision Checklist at https://journals.lww.com/greenjournal/Documents/RevisionChecklist_Authors.pdf and making the applicable edits to your manuscript.

* Figure 3: Please cite within the manuscript text.

REVIEWER COMMENTS:

Reviewer #1: Review of Manuscript ONG-22-1880 "Trends in inpatient hysterectomy rates associated with the COVID-19 Pandemic"

A manuscript that compares the rates of inpatient hysterectomies from 2019 to 2020 in an attempt to evaluate the potential impact of the pandemic on the performance of this common gynecologic surgical procedure has been submitted. The authors utilized data from the National Inpatient Sample in order to compare the frequency of inpatient hysterectomy in these two distinct years. As noted by the authors, differences in the rate of hysterectomy varied, especially during the first few months of the pandemic in the United States. The authors really do not mention if a potential shift to one-day surgery or same day discharge may have also begun and persisted in the 2020 data which I would presume would not be captured in the current data set (the briefly mention this towards the end of the discussion but perhaps it could be expanded - perhaps the pandemic pushed us all to strongly consider outpatient hysterectomies). I have the following

questions and comments.

Title - Consider noting this is based on claims or similar.

Précis - No comments.

Abstract - Minor point - For objective could revise as it reads to me that 2019 was part of the pandemic which it was not in the US.
Line 97 - Consider adding inclusive dates.
Line 105 - Here as well as in the results, consider providing a monthly mean with std. deviation or median with range.

Introduction - Line 149 - Consider adding "…gynecologic services including surgery."

Methods - Line 165 - Could not this was inclusive data which suggests it is for the entire calendar year.
Line 178 - Although a super low number, if a woman had surgery for GTN would that be counted as a cancer or pre-invasive? I suspect there is not enough granularity to evaluate risk reducing hysterectomies?
Line 209 - Considering noting "…acute pandemic period in 2020."

Results - See previous comments about monthly data either in the first paragraph or perhaps around line 231.
Line 226 - Is there more granularity on specific benign pathologic diagnoses?

Discussion - Line 312- Locally advanced cervical cancer really refers to women whose cancers are too large for surgery and thus are treated with chemoradiation. Please revise unless you have data about surgery being used for these women.
Line 360 - Do the authors have reasons on why vaginal hysterectomies may have impacted more?

Tables - Table 1- Provide an * for "Other" race and list what is captured below the table.
Table 2 - No comments

Figures - 1-3 no comments

Supplemental - No comments.

Reviewer #2:
Thank you for the opportunity to participate in the peer review.
I have the following thoughts and questions.

1. As a MIGS surgeon, I am very much appreciative of this work. Relevance to clinical practice is very high. Fills gap. The impact of OR shutdowns on our patients has been enormous yet it has not been documented well and swept under the rug. We can cry all we want about it on Twitter but if it is not published in high profile journal, it does not come to light. This topic will help add to the body of literature and it is we need to advocate for our patients.

2. Methodology, execution, and writing are clear, concise, and to the point. My comments below are more of a matter of style and personal interest, not a "must consider". I tried to make suggestions thinking of what readership might want to hear authors say about certain questions. I listed my comments in the order of priority from high to low.

3. Line 333-334. I would disagree with this statement. When I was working at a Medicaid Hospital in NYC, one of the patients a few years ago bleed to death at home ("benign" AUB). So benign indications are deadly but mostly for the underserved. Not to mention severe anemia that requires transfusions and IV iron for everyone which is a problem for those without access. In my opinion, it is not about the quality of life, which is paramount, but also about real-world morbidity and mortality.

4. Inequities
A. Documenting vs. elaborating (Lines 342-343). Since the authors exposed inequity in this work, then I would ask them to expand on what they think caused it and what they think needs to be done about it. It is becoming a standard in DIE work in academia: it is not enough to document it. Some examples:

We found a disparity, what are we doing to do about it? Imagine and stipulate. One way would be to discuss discussing potential future studies (ex. qualitative research to give patients voices and identification of barriers).

However, I am wondering if the authors might be able to take it a step further. Consider below:

"Documenting racial inequity itself serves as a preliminary step in identifying populations, then situating this inequity in the context of specific pathways that produce disparate health outcomes is needed to identify context-specific interventions….It is common practice for quantitative studies to document conditionally independent associations between race and health outcomes…after adjusting for other individual-level factors such as insurance, education, or income….more attention

should be paid to contextual factors…[of] systemic racism. Imagine and simulate a world where…multiple components of systemic racism are removed" (reference below)

Lett E, Asabor E, Beltrán S, Cannon AM, Arah OA. Conceptualizing, Contextualizing, and Operationalizing Race in Quantitative Health Sciences Research. Ann Fam Med. 2022 Mar-Apr;20(2):157-163. doi: 10.1370/afm.2792. Epub 2022 Jan 19. PMID: 35045967; PMCID: PMC8959750.

B. Systemic racism. I am wondering why systemic racism was not mentioned here.
I thought of a few possibilities (not suggesting those to authors but using them as examples):
-Microaggressions and macro aggressions deter Black women from seeing care
-Anticipated discrimination (internalized racism). Black patients do not trust surgeons to preserve their fertility and, as a result, avoid indicated surgery.

As the authors in the below reference pointed out, "often, studies do not explicitly connect observed disparities to mechanisms of systemic racism that drive adverse health outcomes among racialized and other marginalized groups in the US….Race…is a proxy for exposure to systemic racism. Future studies should go beyond this proxy and directly measure racism and its impacts."

Lett E, Asabor E, Beltrán S, Cannon AM, Arah OA. Conceptualizing, Contextualizing, and Operationalizing Race in Quantitative Health Sciences Research. Ann Fam Med. 2022 Mar-Apr;20(2):157-163. doi: 10.1370/afm.2792. Epub 2022 Jan 19. PMID: 35045967; PMCID: PMC8959750.

c. Hysterectomy numbers never caught up. What happened to those surgeries? Some examples:
-Does that mean that the quality of life of women has been forever affected because they did not get the hysterectomies that they wanted?
-How do these "missing surgeries" in gyn compare to non-GYN specialties? Should we be looking at the "access discrimination gap"? I would argue that we should be, because every time I have to fight for OR time with general surgeons, urologists and orthopods, I wish someone would have written a paper titled "Double Discrimination, the Access gap in Gynecologic Surgery, and Its Association With Quality of Care." Can we measure and study that as a potential future step?

5. How are routes captured in NIS? I assumed via some other billing process and not surgeon CPT codes, since robot and laparoscopic cases are separate in NIS, while they have the same CPT codes. Also, how are LAVHs and supracervical hysterectomies classified in NIS? Other readers might be wondering the same.

6. Lines 267 to 269 and 338-343. When I was reading this, this came to mind. In NYC, in March-June of 2020, here is what happened. Hospital A in Manhattan (which is the gatekeeper for the wealthy with good insurance) never shut down, and kept doing benign hysterectomies just like the pandemic never happened (they did not publicize—would have looked bad to keep elective cases going while patients were dying in hallways in other local hospitals). Meanwhile, Medicaid Hospital B in the Bronx had to fight to do advanced high-grade emCA cases. That's how this work translates into our day-to-day. I would imagine the same played out at Columbia and at UCSF. I was hoping authors would make a stronger statement in this regard because that's what their findings showed, and this study validates moral injury and PTSD doctors and patients got as a result of this inequity.

7. My main question has to do with study design with regard to the breakdown of the route by indication. I understand that the aim of the study was to paint a picture of the volume and a disastrous number of surgeries that never happened that affected patients. However, this is a precious opportunity to do subgroup analysis. For example,
a. If we look at cancer vs. no benign, what does route breakdown look like?
b. Looking at benign indications only, can we look at the route? 75% abdominal and 4% vaginal hyst rate seems very high/low, even for the inpatient setting, and I am guessing that cancer debulking as well as leakage of MIS cases to ambulatory setting affected that number.

8. From the methodology standpoint, do SDS (same-day surgery) cases go into NIS? For example, while 95% of benign cases are MIS in my MIGS setting, most of them are still done in the main hospital ORs, mostly because stand-alone ambulatory surgical centers are not taking those cases (it is not medical, but logistical money/resource issue). So those same-day discharge MIS hysterectomies go to NIS or not and are they considered to be inpatient or not? I assume not, but I am guessing many readers would be wondering the same thing.

9. Indications: I did not see prolapse on that list. Was this omission intentional, and if so why? If not, then is it a limitation of the database?

10. Intro lines 148-155. The first sentence mentions references 5-7, but the following sentences do not have references listed so not clear which of the 3 papers listed are discussed in those sentences.

11. What do authors think about outpatient volume and would it look similar?

12. Is inpatient hysterectomy a proxy for other procedures, or so authors expect to see something different (ex. endometriosis excision, myomectomy).

13. VH numbers.

This is my personal area of interest.

While in the past, all benign indications, including prolapse, were lumped together, we were getting something around 11% VH rates, which was a disastrous trend.

This is the first recent study to my knowledge that showed VH for benign indications only, no prolapse included. It is not surprising to me since that's what I see in practice, but it was 3.8% in 2020!!!! I think this is a major finding, and we (doctors, society, and professional societies) should be held accountable. We need to explain to our patients why despite ACOG saying for years that VH is best, and when 30-50% of benign hysts can be done vaginally we are now down to 3.8% VH rate, and why ACOG efforts to promote VH have consistently failed. In addition, I assume, VHs are in the hands of very few (so not evenly distributed geographically and between surgeons). I can see why authors would not want to focus on this in their paper since it is not their aims, but when one finds something major and unexpected, should it be emphasized and highlighted or at least put into context?

STATISTICAL EDITOR'S COMMENTS:
The supplemental digital content, Table 1 shows the relationship between the weighted and unweighted sample sizes. For many readers, the Tables in main text will be interpreted as if those were actual enumerated counts, rather than weighted, estimated counts extrapolated to the entire US population. In fact, the NIS counts were ~ 30 k for 2019 and ~ 24 k for 2020. The Table 1 in supplemental (or a flow diagram format of same information) should be in main text with clear statement in Abstract and Results of the relationship between survey counts and weighted, extrapolated counts.

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Sincerely,

Vivian W. Sung, MD, MPH
Deputy Editor, Gynecology–Elect

The Editors of Obstetrics & Gynecology

December 5, 2022

Dear Dr. Sung,

Thank you for the opportunity to submit our work to *Obstetrics & Gynecology*. After our discussion, we have extensively modified the manuscript to address the reviewer's comments. This includes the addition of data from a second data source that recently became available, the National Ambulatory Surgical Sample. Given the increased amount of data and analysis we retained the manuscript as an original research report. Below, please find point-by-point responses to each of the comments raised in the peer review.

Editor Comments

1. We would like to offer the opportunity to submit this work as a research letter.

To address comments from the reviewers we added data from the National Ambulatory Surgical Sample (NASS). NASS captures data on outpatient procedures. After the time of our initial submission, NASS data from 2020 was released allowing us to examine the COVID-19 pandemic. Given the increased amount of data we retained the manuscript as an original research report.

2. Figure 3: Please cite within the manuscript text.

This has been cited.

Reviewer #1

1. Title - Consider noting this is based on claims or similar.

The title has been revised.

2. Abstract - Minor point - For objective could revise as it reads to me that 2019 was part of the pandemic which it was not in the U.S.

The Abstract has been modified as suggested.

3. Line 97 - Consider adding inclusive dates.

The Abstract has been modified as suggested.

4. Line 105 - Here as well as in the results, consider providing a monthly mean with std. deviation or median with range.

The actual number of procedures performed each month is displayed in the Figure. Given the dramatic month to month shifts in the number of procedures during 2020 we believe that overall means and medians are of limited value.

5. Introduction - Line 149 - Consider adding "…gynecologic services including surgery." –

This has been changed as suggested.

6. Methods - Line 165 - Could not this was inclusive data which suggests it is for the entire calendar year.

This is for calendar year. We have clarified this in the manuscript.

7. Line 178 - Although a super low number, if a woman had surgery for GTN would that be counted as a cancer or pre-invasive? I suspect there is not enough granularity to evaluate risk reducing hysterectomies?

Given the very low numbers of hysterectomy for GTN we did not classify this as a unique indication for hysterectomy.

8. Line 209 - Considering noting "…acute pandemic period in 2020."

This has been changed as suggested.

9 Results - See previous comments about monthly data either in the first paragraph or perhaps around line 231.

As above, we believe overall inclusion of either mean or median is of minimal value as there were rapid shifts over time in monthly volume.

10. Discussion - Line 312- Locally advanced cervical cancer really refers to women whose cancers are too large for surgery and thus are treated with chemoradiation. Please revise unless you have data about surgery being used for these women.

This paper does not specifically indicate surgery as the only treatment modality that was prioritized for these groups, only that these groups were prioritized for treatment. The wording in the discussion has been changed accordingly to improve clarity.

11. Line 360 - Do the authors have reasons on why vaginal hysterectomies may have impacted more?

Many of these procedures are urogynecologic procedures that are elective in nature and frequent in elderly patients. As such, these procedures were among those most likely to be delayed due to the COVID-19 pandemic.

12. Tables - Table 1- Provide an * for "Other" race and list what is captured below the table.

This has been added as suggested.

Reviewer #2

1. As a MIGS surgeon, I am very much appreciative of this work. Relevance to clinical practice is very high. Fills gap. The impact of OR shutdowns on our patients has been enormous yet it has not been documented well and swept under the rug. We can cry all we want about it on Twitter but if it is not published in high profile journal, it does not come to light. This topic will help add to the body of literature and it is we need to advocate for our patients.

We appreciate the Reviewer's comment and certainly concur with the importance of the topic.

2. Methodology, execution, and writing are clear, concise, and to the point. My comments below are more of a matter of style and personal interest, not a "must consider". I tried to make suggestions thinking of what readership might want to hear authors say about certain questions. I listed my comments in the order of priority from high to low.

We appreciate the careful review and feedback.

3. Line 333-334. I would disagree with this statement. When I was working at a Medicaid Hospital in NYC, one of the patients a few years ago bleed to death at home ("benign" AUB). So benign indications are deadly but mostly for the underserved. Not to mention severe anemia that requires transfusions and IV iron for everyone which is a problem for those without access. In my opinion, it is not about the quality of life, which is paramount, but also about real-world morbidity and mortality.

We agree with this comment. The distinction is based on pathologic classification and not on symptom burden and we did not intend to make such a value judgement. Undoubtedly a patient with significant pain or bleeding likely has a greater decrement in quality of life than a patient with a small, indolent endometrial cancer. The manuscript text has been changed slightly to omit the possibility of misreading the text as expressing that benign pathologies are not not associated with significant morbidity.

4. Inequities

A. Documenting vs. elaborating (Lines 342-343). Since the authors exposed inequity in this work, then I would ask them to expand on what they think caused it and what they think needs to be done about it. It is becoming a standard in DIE work in academia: it is not enough to document it. Some examples:

We found a disparity, what are we doing to do about it? Imagine and stipulate. One way would be to discuss discussing potential future studies (ex. qualitative research to give patients voices and identification of barriers).

However, I am wondering if the authors might be able to take it a step further. Consider below:

"Documenting racial inequity itself serves as a preliminary step in identifying populations, then situating this inequity in the context of specific pathways that produce disparate health outcomes is needed to identify context-specific interventions….It is common practice for quantitative studies to document conditionally independent associations between race and health outcomes…after adjusting for other individual-level factors such as insurance, education, or income….more attention should be paid to contextual factors…[of] systemic racism. Imagine and simulate a world where…multiple components of systemic racism are removed" (reference below)

Lett E, Asabor E, Beltrán S, Cannon AM, Arah OA. Conceptualizing, Contextualizing, and Operationalizing Race in Quantitative Health Sciences Research. Ann Fam Med. 2022 Mar-Apr;20(2):157-163. doi: 10.1370/afm.2792. Epub 2022 Jan 19. PMID: 35045967; PMCID: PMC8959750.

We certainly agree with this comment. The current analysis is simply a patterns of care study to document hysterectomy performance during the COVID-19 pandemic. In our revised analysis there were no differences in race or insurance status during the COVID-19 pandemic period in 2020.

B. Systemic racism. I am wondering why systemic racism was not mentioned here.
I thought of a few possibilities (not suggesting those to authors but using them as examples):
-Microaggressions and macro aggressions deter Black women from seeing care
-Anticipated discrimination (internalized racism). Black patients do not trust surgeons to preserve their fertility and, as a result, avoid indicated surgery.

As the authors in the below reference pointed out, "often, studies do not explicitly connect observed disparities to mechanisms of systemic racism that drive adverse health outcomes among racialized and other marginalized groups in the US….Race…is a proxy for exposure to systemic racism. Future studies should go beyond this proxy and directly measure racism and its impacts."

Lett E, Asabor E, Beltrán S, Cannon AM, Arah OA. Conceptualizing, Contextualizing, and Operationalizing Race in Quantitative Health Sciences Research. Ann Fam Med. 2022 Mar-Apr;20(2):157-163. doi: 10.1370/afm.2792. Epub 2022 Jan 19. PMID: 35045967; PMCID: PMC8959750.

As above, we agree that systemic racism likely influenced the patterns of care we observed. In our revised analysis there were no differences in race or insurance status during the COVID-19 pandemic period in 2020.

c. Hysterectomy numbers never caught up. What happened to those surgeries? Some examples:
-Does that mean that the quality of life of women has been forever affected because they did not get the hysterectomies that they wanted?
-How do these "missing surgeries" in gyn compare to non-GYN specialties? Should we be

looking at the "access discrimination gap"? I would argue that we should be, because every time I have to fight for OR time with general surgeons, urologists and orthopods, I wish someone would have written a paper titled "Double Discrimination, the Access gap in Gynecologic Surgery, and Its Association With Quality of Care." Can we measure and study that as a potential future step?

We agree with all of these potential concerns. “What happened” to these hysterectomies is unclear. Potentially more patients were managed medically or with other alternative therapies. As our study is based on claims data we are unable to determine trends in other treatments during this time period. This however clearly warrants further study.

5. How are routes captured in NIS? I assumed via some other billing process and not surgeon CPT codes, since robot and laparoscopic cases are separate in NIS, while they have the same CPT codes. Also, how are LAVHs and supracervical hysterectomies classified in NIS? Other readers might be wondering the same.

The NIS database uses ICD-10 coding for various procedures and routes of procedure. This provides some increased granularity compared to CPT codes alone. NASS only includes CPT codes which are unable to distinguish robotic-assisted and laparoscopic procedures. Are revised classification system includes abdominal, laparoscopic (including robotic-assisted) and vaginal hysterectomy.

6. Lines 267 to 269 and 338-343. When I was reading this, this came to mind. In NYC, in March-June of 2020, here is what happened. Hospital A in Manhattan (which is the gatekeeper for the wealthy with good insurance) never shut down, and kept doing benign hysterectomies just like the pandemic never happened (they did not publicize—would have looked bad to keep elective cases going while patients were dying in hallways in other local hospitals). Meanwhile, Medicaid Hospital B in the Bronx had to fight to do advanced high-grade emCA cases. That's how this work translates into our day-to-day. I would imagine the same played out at Columbia and at UCSF. I was hoping authors would make a stronger statement in this regard because that's what their findings showed, and this study validates moral injury and PTSD doctors and patients got as a result of this inequity.

We certainly agree with the comment, but this level of hospital granularity is difficult to discern let alone quantitate from administrative data sources. We have attempted to describe the data and place these findings into context in the Discussion.

7. My main question has to do with study design with regard to the breakdown of the route by indication. I understand that the aim of the study was to paint a picture of the volume and a disastrous number of surgeries that never happened that affected patients. However, this is a precious opportunity to do subgroup analysis. For example,
a. If we look at cancer vs. no benign, what does route breakdown look like?
b. Looking at benign indications only, can we look at the route? 75% abdominal and 4% vaginal hyst rate seems very high/low, even for the inpatient setting, and I am guessing that cancer debulking as well as leakage of MIS cases to ambulatory setting affected that number.

We agree that these are all important questions but beyond the scope of the current analysis. In this report we aimed to document patterns of care. The points above are clearly worthy of further study.

8. From the methodology standpoint, do SDS (same-day surgery) cases go into NIS? For example, while 95% of benign cases are MIS in my MIGS setting, most of them are still done in the main hospital ORs, mostly because stand-alone ambulatory surgical centers are not taking those cases (it is not medical, but logistical money/resource issue). So those same-day discharge MIS hysterectomies go to NIS or not and are they considered to be inpatient or not? I assume not, but I am guessing many readers would be wondering the same thing.

Lack of data on ambulatory surgery was a major limitation of the analysis. Since submission, 2020 data on outpatient procedures in the National Ambulatory Surgery Sample was released. This new data has been incorporated into the current analysis.

9. Indications: I did not see prolapse on that list. Was this omission intentional, and if so why? If not, then is it a limitation of the database?

Pelvic organ prolapse was included, it was an oversight not to list in the Methods. This has been corrected.

10. Intro lines 148-155. The first sentence mentions references 5-7, but the following sentences do not have references listed so not clear which of the 3 papers listed are discussed in those sentences.

This has been added as suggested.

11. What do authors think about outpatient volume and would it look similar?

As described above we now have data on outpatient procedures included.

12. Is inpatient hysterectomy a proxy for other procedures, or so authors expect to see something different (ex. endometriosis excision, myomectomy).

It is difficult to say whether outpatient volume would be different or the same given that unprecedented nature of the COVID-19 pandemic. Additionally study is ongoing to examine other procedures.

13. VH numbers.

This is my personal area of interest.

While in the past, all benign indications, including prolapse, were lumped together, we were getting something around 11% VH rates, which was a disastrous trend.

This is the first recent study to my knowledge that showed VH for benign indications only, no

prolapse included. It is not surprising to me since that's what I see in practice, but it was 3.8% in 2020!!!! I think this is a major finding, and we (doctors, society, and professional societies) should be held accountable. We need to explain to our patients why despite ACOG saying for years that VH is best, and when 30-50% of benign hysts can be done vaginally we are now down to 3.8% VH rate, and why ACOG efforts to promote VH have consistently failed. In addition, I assume, VHs are in the hands of very few (so not evenly distributed geographically and between surgeons). I can see why authors would not want to focus on this in their paper since it is not their aims, but when one finds something major and unexpected, should it be emphasized and highlighted or at least put into context?

This is an important point. A major caveat is that this data reflects only inpatient procedures and many vaginal hysterectomies were likely ambulatory surgeries. Further work is needed to explore trends in vaginal hysterectomy over time.

STATISTICAL EDITOR'S COMMENTS

1. The supplemental digital content, Table 1 shows the relationship between the weighted and unweighted sample sizes. For many readers, the Tables in main text will be interpreted as if those were actual enumerated counts, rather than weighted, estimated counts extrapolated to the entire US population. In fact, the NIS counts were ~ 30 k for 2019 and ~ 24 k for 2020. The Table 1 in supplemental (or a flow diagram format of same information) should be in main text with clear statement in Abstract and Results of the relationship between survey counts and weighted, extrapolated counts.

The Table describing the relationship between unweighted and weighted counts has been moved to the main document as suggested. Inclusion of the NASS data has greatly expanded the sample size so power is of lower concern. We have added to both the Results and Abstract that numbers represented weighted cases.

Again, thank you for the opportunity to submit our work. If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

Jason D. Wright, M.D.