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

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

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Questions about these materials may be directed to the Obstetrics & Gynecology editorial office: obgyn@greenjournal.org.
RE: Manuscript Number ONG-18-2074

GROSS AND HISTOLOGIC ANATOMY OF THE PELVIC URETER: CLINICAL APPLICATIONS TO PELVIC SURGERY

Dear Dr. Jackson:

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 Jan 25, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

REVIEWER #1:

In this manuscript, the authors present a study of 30 cadaver dissections to describe the course of the female ureter. The authors also perform histologic investigations among 5 cadavers to understand the histologic composition of tissues around the ureter at it passes near the cervix. The authors appear familiar with the usual cadaver study pitfalls - dissection distortions, drying tissue, etc. I personally like anatomic studies although I often wonder how it is these can be relevant. The human body has been dissected for centuries can there be anything we don't know yet? The short answer is, "yes" but I still find it puzzling. This study demonstrates that the ureter is indeed very close to the ovarian blood supply as well as to the cervix and vaginal cuff attesting to these being the sites where most injuries occur. I would be very surprised the average OB/GYN operating in these spaces has any idea of the short distances at work here and its remarkable that there are not more injuries. I have the following specific comments/questions:

1) The paragraph starting at 230: A figure would be helpful to convey what you're trying to say here. I don't gather there is any clinical relevance to whether the ureter passes over the bifurcation on the right or left but then I'm not sure why this information is shared.

2) The meat of this study comes around lines 287. The measurements are put into context and a figure demonstrating what this risk is would be highly useful. In contrast, the 0.8cm measurement of the ureter at the pelvic brim is not so helpful. The proximity of the ureter here belies the fact that proper technique can usually mobilize the ovarian vessels well away from the ureter that should be identified prior to taking down this pedicle. I suppose I shouldn't assume proper technique is commonplace but then again the rate of injuries is still pretty low. The aforementioned figure could also include the relationship described in lines 294-298.

3) Given the ease with which passing a stent/guidewire out the ureter can be I'm very dubious of the resistance lessons that are attempted in lines 306-309. The infrequency most OB/GYNs are having w/ placing a stent would also give me no confidence this resistance sense would be detectable.

4) The inferior hypogastric plexus would be delivering sympathetic nerve input to this part of the body. It would be helpful to state this and what this might do to the surrounding tissues. Much of this can get confusing. For example, performing a presacral neurectomy should create a parasympathetic dominance to pelvic organs and correspondingly symptoms of hyperactive bowel or bladder but often the reverse (e.g. constipation) is reported. Still, a reader is much more likely to understand/remember these nerves if they knew what they do.

5) Figure 1 would be better if the blue lines were double-headed arrows thus depicting a measured distance.
6) Figure 3, just at 5mm to the line just under "A." You do this on another figure and it works better.

Overall, some of the work here could be very helpful particularly if another figure were prepared that showed relevance dissections/clamps being placed relative to the measured distance ranges. The measurements are not that interesting outside of the clinical context so more depiction of that seems logical.

REVIEWER #2:

Well written article.

Figures and cadaveric pictures are the most crucial of this paper in general. Anatomy is very well described.

1. Figure 1. item #4 is not labeled.

2. Figure 3 can be eliminated, especially panels B-F. Panel A maybe of some value as it describes the anatomical location of the ureter to uterine artery and how close it is when the uterine arteries are ligated during a hysterectomy.

3. The ureter and its anatomical location is very well described and anatomically well show in figure 5. Demonstrates the its relative proximity to the vaginal sidewall and the anterior vaginal wall. One of the key points made during the paper is during bladder dissection off of the anterior cervix and vagina, keeping medial as to not injure the ureter which are in close proximity laterally in the ureteral canal in the cardinal ligaments. Figure 6 emphasizes good knowledge of this anatomy showing cross section of the proximity of the ureter to the cervix to the bladder.

4. The author comment on avoiding the tissue posterior to the ureter might decrease the risk of nerve injury and therefore postoperative voiding dysfunction is presumptuous and needs to be supported with surgical clinical outcome data that this reviewer is not aware exists. If it does, it needs to be appropriately referenced.

5. The main deficit to this paper is it overall utility in offering new information that we otherwise not know about it. Certainly the information and its focus on ureter is unique and helpful but could be found in other anatomy literature.

REVIEWER #3:

Good study with one specific statistical request. The use of SD is of uncertain significance to me due to the general lack of information regarding the anticipated distribution of the measurements and whether a normal distribution can/should be assumed. Because one of the strengths of this study is the number of cadavers that were measured, the full interpretation of the data should include a discussion regarding the expected variations a surgeon could encounter. Useful measures of the distribution type are measures of Skewness and Kurtosis with expectations of values of 0 and 3 respectively for a normally distributed set of data. It is possible that more useful measures would be max/min and median values if the distributions are not normal or skewed. Of course, as the exact computed kurtosis and skewness would be estimates, you won’t get exactly 0 or 3 but a statistician could weigh in on your results. Likewise, a bimodal distribution of your data for certain measurements would more strongly argue for a need for further research to evaluate population differences. In my opinion, it would be a shame to lose that level of detail of your data.

I acknowledge that including the specific skewness and kurtosis measures is NOT needed but that analysis could bring some important insights. As an example, another article from "Good et al. Vascular and ureteral anatomy in sacrocolpexy. Am J Obstet Gynecol 2013." tackled the issue of measurements relative to the midpoint of the sacral promontory with both +/- SD and full value ranges. I think inclusion of that information should be a minimal addition for publication as that information suggests pretty clearly when data might not be either symmetric or normally distributed as it does in their paper without computing skewness or kurtosis measures. See their Table 2 as an example. (I had nothing to do with that publication btw... )

Finally, a further comment on any observed variations between with hysterectomy and without hysterectomy patient data would be interesting.

STATISTICAL EDITOR’S COMMENTS:

Table 1: The sample size of 30 is adequate to estimate the mean and SD, but would also suggest describing more information re: the variability, so would include the range for each measure length.

Table 2: Some of these samples are smaller (n = 10 or 20) so, should cite as median(range) rather than assuming a normal distribution that mean ± SD would imply. The use of ranges would strengthen the Author’s discussion re: the proximity of ureters to other vital structure.

Beautiful diagrams and pictures!
EDITORIAL OFFICE COMMENTS:

1. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter, as well as subsequent author queries. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:
   1. OPT-IN: Yes, please publish my response letter and subsequent email correspondence related to author queries.
   2. OPT-OUT: No, please do not publish my response letter and subsequent email correspondence related to author queries.

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

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

3. 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.

4. Tables, figures, and supplemental digital content should be original. The use of borrowed material (eg, lengthy direct quotations, tables, figures, or videos) is discouraged, but should it be considered essential, written permission of the copyright holder must be obtained. Permission is also required for material that has been adapted or modified from another source. Both print and electronic (online) rights must be obtained from the holder of the copyright (often the publisher, not the author), and credit to the original source must be included in your manuscript. Many publishers now have online systems for submitting permissions request; please consult the publisher directly for more information.

5. 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), 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, 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 and gynecology data definitions at https://www.acog.org/About-ACOG/ACOG-Departments/Patient-Safety-and-Quality-Improvement/reVITALize. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

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 26 typed, double-spaced pages (6,500 words. Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

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 limits for different article types are as follows: Original Research articles, 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.

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

13. Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: http://edmgr.ovid.com/ong/accounts/table_checklist.pdf.

14. The Journal's Production Editor had the following to say about the figures in your manuscript:

"Figure 1–2: Please provide a letter of permission from the illustrator allowing for use in print and electronic publication. Figure 4: Please provide another version without any text or arrows. These will be added back per journal style. Figure 5: Please provide another version without any text or arrows (please keep the red lines). These will be added back per journal style. Figure 6: Please provide another version without any text or arrows (please leave the blue lines). These will be added back per journal style."

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

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

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

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

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

Again, your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Jan 25, 2019, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,
The Editors of Obstetrics & Gynecology

2017 IMPACT FACTOR: 4.982
2017 IMPACT FACTOR RANKING: 5th out of 82 ob/gyn journals

In compliance with data protection regulations, please contact the publication office if you would like to have your personal information removed from the database.
January 22nd, 2019

Re: Revisions to the submission of manuscript, “Gross and Histologic Anatomy of the Pelvic Ureter: Clinical Applications to Pelvic Surgery”

The Editors

Obstetrics & Gynecology

409 12th Street, SW

Washington, DC 20024-2188

Dear Editors,

On behalf of my co-authors, I am pleased to submit our revisions to our manuscript “Gross and Histologic Anatomy of the Pelvic Ureter: Clinical Applications to Pelvic Surgery” for consideration for publication as original research in Obstetrics & Gynecology. Reviewers comments with our correspondence is below. Each author participated actively in gathering data, conducting analyses, drafting sections of the manuscript, editing, and approving the final, submitted version. None of the authors has a financial or other conflict of interest. As the lead author, I 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.

This study was exempt by our institutional board review. The manuscript has not been previously published or submitted to another journal for publication. We have followed the STROBE guidelines.

Our manuscript is the first to provide a comprehensive and quantitate analysis of nerve density across the entire length of the distal ureter. In addition, it also provides new information on pelvic segment ureter lengths and relationships to important surgical landmarks. We look forward to your comments and critique.

We would like to suggest that Figure 2 be considered as cover art.

If you have any questions, I will be serving as the corresponding author. Thank you for your consideration.

Sincerely,

Lindsey Jackson, MD
REVIEWER COMMENTS:

REVIEWER #1:

In this manuscript, the authors present a study of 30 cadaver dissections to describe the course of the female ureter. The authors also perform histologic investigations among 5 cadavers to understand the histologic composition of tissues around the ureter at it passes near the cervix. The authors appear familiar with the usual cadaver study pitfalls - dissection distortions, drying tissue, etc. I personally like anatomic studies although I often wonder how it is these can be relevant. The human body has been dissected for centuries can there be anything we don't know yet? The short answer is, "yes" but I still find it puzzling. This study demonstrates that the ureter is indeed very close to the ovarian blood supply as well as to the cervix and vaginal cuff attesting to these being the sites where most injuries occur. I would be very surprised the average OB/GYN operating in these spaces has any idea of the short distances at work here and its remarkable that there are not more injuries. I have the following specific comments/questions:

Reply: We appreciate reviewer’s comments. Below are itemized answers to comments and questions.

1) The paragraph starting at 230: A figure would be helpful to convey what you’re trying to say here. I don’t gather there is any clinical relevance to whether the ureter passes over the bifurcation on the right or left but then I’m not sure why this information is shared.

Reply: Agree referencing a Figure here would be helpful. As we already have 6 Figures in this manuscript, Figures 1 and 2 demonstrate the passing over the bifurcation and over the external iliac artery, respectively. We think the main clinical relevance is for trainees and young surgeons to be aware that about half the time, the ureter actually crosses over the external iliac vessels and not the bifurcation. This may be useful in setting of dense adhesions or bleeding over the pelvic brim region. In our study, we never found the ureter entering pelvis medial to bifurcation. Again this may be useful in setting of altered anatomy or bleeding.

We have added a sentence to the Discussion, lines 307-311. We have also referenced Figure 5 in Results (line 246). We agree that there is no clinical significance into separating this finding into a right and left side; we have combined the right and left sides and reported as a combined percent (line 246).

2) The meat of this study comes around lines 287. The measurements are put into context and a figure demonstrating what this risk is would be highly useful. In contrast, the 0.8cm measurement of the ureter at the pelvic brim is not so helpful. The proximity of the ureter here belies the fact that proper technique can usually mobilize the ovarian vessels well away from the ureter that should be identified prior to taking down this pedicle. I suppose I shouldn’t
assume proper technique is commonplace but then again the rate of injuries is still pretty low. The aforementioned figure could also include the relationship described in lines 294-298.

Reply: We agree with reviewer’s comments. Although it is common knowledge that ureter is medial to and in close proximity to ovarian vessels prior to manipulation of peritoneum or infundibulopelvic ligament, scarce information is presented on Textbooks on what the actual distances between these 2 structures are at rest. This may be useful in setting of adhesions or other pathology that obscure normal anatomy. In these settings, if ovarian vessels can be clearly seen, the expected location of the ureter, just medial to and close to vessels can be anticipated. This information is mostly useful for physicians in training but we think worth reporting.

3) Given the ease with which passing a stent/guidewire out the ureter can be I'm very dubious of the resistance lessons that are attempted in lines 306-309. The infrequency most OB/GYNs are having w/ placing a stent would also give me no confidence this resistance sense would be detectable.

Reply: We agree with reviewer that stent placement is infrequently done by Obstetricians and Gynecologists. However, it is important to pelvic surgeons who are asked to evaluate for possible ureteral injury intraoperatively and manage these injuries, when confirmed. We believe this clinical correlate based on our findings will be useful to them.

4) The inferior hypogastric plexus would be delivering sympathetic nerve input to this part of the body. It would be helpful to state this and what this might do to the surrounding tissues. Much of this can get confusing. For example, performing a presacral neurectomy should create a parasympathetic dominance to pelvic organs and correspondingly symptoms of hyperactive bowel or bladder but often the reverse (e.g. constipation) is reported. Still, a reader is much more likely to understand/remember these nerves if they knew what they do.

Reply: Agree with reviewer’s comments that autonomic innervation to pelvic organs, specifically that of the inferior hypogastric plexus can be confusing, partly because this anatomy is not generally appreciated in surgery or even during cadaver dissections. This anatomy and its clinical applications was covered in detailed in one of our prior cadaveric studies referenced in this paper (Reference # 17, Ripperda et al) and a brief comment has been added to this paper in lines 342-346.

5) Figure 1 would be better if the blue lines were double-headed arrows thus depicting a measured distance.

Reply: This figure has been revised.

6) Figure 3, just at 5mm to the line just under "A." You do this on another figure and it works
January 22\textsuperscript{nd}, 2019

better.

Reply: We agree that the 5 mm in panel A would look better, however the “100 um” text for the scale bar in panel B would exceed bar length. We will defer this to the Journal Production Editor.

Overall, some of the work here could be very helpful particularly if another figure were prepared that showed relevance dissections/clamps being placed relative to the measured distance ranges. The measurements are not that interesting outside of the clinical context so more depiction of that seems logical.

REVIEWER #2:

Well written article.

Figures and cadaveric pictures are the most crucial of this paper in general. Anatomy is very well described.

Reply: We appreciate reviewer #2 Comments. Below are our responses.

1. Figure 1. item #4 is not labeled.

Reply: Item #4 is labeled in the figure and discussed in Figure 1 legend. This Figure has been updated.

2. Figure 3 can be eliminated, especially panels B-F. Panel A maybe of some value as it describes the anatomical location of the ureter to uterine artery and how close it is when the uterine arteries are ligated during a hysterectomy.

Reply: We respectfully disagree as this Figure illustrates the detailed Methods used to determine nerve density. As the Methods for this section is somewhat cumbersome, we believe the Figure will assist the reader in better understanding this section. It is not only describing location of the ureter to uterine artery but illustrating the detailed descriptions of the methods used.

We did change the title of Figure 3 legend to clarify this Figure details the methods used for nerve density analysis in representative contiguous cross sections through parametrium.

3. The ureter and its anatomical location is very well described and anatomically well show in figure 5. Demonstrates the its relative proximity to the vaginal sidewall and the anterior vaginal wall. One of the key points made during the paper is during bladder dissection off of the anterior cervix and vagina, keeping medial as to not injure the ureter which are in close
proximity laterally in the ureteral canal in the cardinal ligaments. Figure 6 emphasizes good knowledge of this anatomy showing cross section of the proximity of the ureter to the cervix to the bladder.

Reply: Appreciate reviewer’s comments.

4. The author comment on avoiding the tissue posterior to the ureter might decrease the risk of nerve injury and therefore postoperative voiding dysfunction is presumptuous and needs to be supported with surgical clinical outcome data that this reviewer is not aware exists. If it does, it needs to be appropriately referenced.

Reply: Appreciate reviewer’s comments. This has been addressed in lines 343-346 of the revised word document manuscript and additional references provided.

5. The main deficit to this paper is it overall utility in offering new information that we otherwise not know about it. Certainly the information and its focus on ureter is unique and helpful but could be found in other anatomy literature.

Reply: Although selective information can be found in various sources by extensively reviewing the literature, our descriptive study presents the information in the setting of careful dissections in a relatively large number of cadavers and also examines histologic and nerve density findings in distal part of the ureter in order to provide clinical correlations.

REVIEWER #3:

Good study with one specific statistical request. The use of SD is of uncertain significance to me due to the general lack of information regarding the anticipated distribution of the measurements and whether a normal distribution can/should be assumed. Because one of the strengths of this study is the number of cadavers that were measured, the full interpretation of the data should include a discussion regarding the expected variations a surgeon could encounter. Useful measures of the distribution type are measures of Skewness and Kurtosis with expectations of values of 0 and 3 respectively for a normally distributed set of data. It is possible that more useful measures would be max/min and median values if the distributions are not normal or skewed. Of course, as the exact computed kurtosis and skewness would be estimates, you won’t get exactly 0 or 3 but a statistician could weigh in on your results. Likewise, a bimodal distribution of your data for certain measurements would more strongly argue for a need for further research to evaluate population differences. In my opinion, it would be a shame to lose that level of detail of your data.

I acknowledge that including the specific skewness and kertosis measures is NOT needed but that analysis could bring some important insights. As an example, another article from "Good et al. Vascular and ureteral anatomy in sacrocolpexy. Am J Obstet Gynecol 2013." tackled the issue
of measurements relative to the midpoint of the sacral promontory with both +/- SD and full value ranges. I think inclusion of that information should be a minimal addition for publication as that information suggests pretty clearly when data might not be either symmetric or normally distributed as it does in their paper without computing skewness or kertosis measures. See their Table 2 as an example. (I had nothing to do with that publication btw... )

Reply: Appreciate insightful reviewer’s comments and agree that including total ranges will be clinically useful. We have added the ranges to Tables 1 and 2 and modified Table 2 to include only median (range) based on Statistical Editor’s Comments.

Finally, a further comment on any observed variations between with hysterectomy and without hysterectomy patient data would be interesting.

Reply: There was no statistically significant difference (p>0.05) in measurements between specimens with a uterus and without a uterus, we have added this in lines 268-269. P-values not presented in table as n in general relatively small with unequal numbers in 2 groups. Let us know if this is acceptable or if more information needed.

STATISTICAL EDITOR’S COMMENTS:

Table 1: The sample size of 30 is adequate to estimate the mean and SD, but would also suggest describing more information re: the variability, so would include the range for each measure length.

Reply: Appreciate Statistical Editor’s Comments. We have included the total range for each measured length in Table 1.

Table 2: Some of these samples are smaller (n = 10 or 20) so, should cite as median(range) rather than assuming a normal distribution that mean ± SD would imply. The use of ranges would strengthen the Author’s discussion re: the proximity of ureters to other vital structure.

Reply: Agree. We have changed to median (range) for all values presented in Table 2

Beautiful diagrams and pictures!

EDITORIAL OFFICE COMMENTS:

1. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter, as well as subsequent author queries. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:
January 22nd, 2019

1. OPT-IN: Yes, please publish my response letter and subsequent email correspondence related to author queries.

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

   Reply: We appreciate the Editorial Office Comments. We would like to OPT-IN and have provided a point-by-point response to the Reviewers and Editors Comments.

3. 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.

   Reply: This has been done.

4. Tables, figures, and supplemental digital content should be original. The use of borrowed material (eg, lengthy direct quotations, tables, figures, or videos) is discouraged, but should it be considered essential, written permission of the copyright holder must be obtained. Permission is also required for material that has been adapted or modified from another source. Both print and electronic (online) rights must be obtained from the holder of the copyright (often the publisher, not the author), and credit to the original source must be included in your manuscript. Many publishers now have online systems for submitting permissions request; please consult the publisher directly for more information.

   Reply: We have submitted a letter from our illustrator.

5. 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), 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

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January 22\textsuperscript{nd}, 2019

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, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

Reply: This has been done and submitted.

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

Reply: A word count has been added.

14. The Journal's Production Editor had the following to say about the figures in your manuscript:

Reply: We appreciate the Journal’s Production Editor’s suggestions and have completed the below following requirements.

"Figure 1–2: Please provide a letter of permission from the illustrator allowing for use in print and electronic publication.

Figure 4: Please provide another version without any text or arrows. These will be added back per journal style.

Figure 5: Please provide another version without any text or arrows (please keep the red lines). These will be added back per journal style.

Figure 6: Please provide another version without any text or arrows (please leave the blue lines). These will be added back per journal style."

Reply: We have provided all above and saved all images as high-definition TIFFs at 600 dpi.

15. The web editor has reviewed your manuscript and would like to encourage you to submit a video to accompany your manuscript. The video file may be uploaded with your revised submission as "supplemental digital content." Acceptable file types include .wmv, .swf, .flv, .mov, .mp4, .avi, .mpg, .mpeg, or .m4v. The file may not exceed 100 MB. The video will accompany your article as supplemental digital content on the Green Journal web site, be displayed in the journal's video gallery, and also be uploaded to the journal's YouTube channel.
January 22nd, 2019

(if deemed appropriate by the editors). If you have questions prior to submission, please contact the journal's production editor at obgyn@greenjournal.org.

Reply: We will be unable to submit a video at this time.
Mr. Mosier,

Thanks so much! I have read through the attached file and made a few changes as outlined below and in the attached document. Please let me know if there is anything else you need from me!

1. Please note the minor edits and deletions throughout. Please let us know if you disagree with any of these changes.
   Reply: I agree with all the changes and have put in a few edits to clarify the below questions/comments.
2. LINE 28: Drs. Spirtos and Pedersen will need to complete our electronic Copyright Transfer Agreement, which was sent to them through Editorial Manager.
   Reply: Thank you, I spoke to them about this yesterday and they have completed this.
3. LINE 50: Add the type of study you conducted to this section.
   Reply: this has been added
4. LINE 61: Table 1 says 4.5-11.5. Which is correct?
   Reply, thank you for catching this, 4.5-11.5 (the table) is correct and I have changed it in the document I have attached this this email
5. LINE 64: Where is the 0.4 represented in the body text, tables, or figures? Please be sure it is represented somewhere other than the abstract.
   Reply: We had decided to report these values as medians with (range) only. Thank you for catching this, I have corrected these values to median (range) it in the attached document.
6. LINE 65: The data listed for right and left in Table 2 are different. What you have here only applies to the left. Please edit as needed.
   Reply: this has also been done.
7. LINE 66: The data listed here are not consistent with what is stated in Table 2. Please review and edit as needed. Information in the abstract must also be stated elsewhere.
   Reply: this has also been done and this data is reported in Table 2.
8. LINE 102: Add the type of study you conducted to this section.
   Reply: This has been added.
9. LINE 199: Please clarify the exact marker that should be same as described in Fig 3 – and line 207, 210, etc
   Reply: This has been corrected.
10. TABLE 1: Abstract says 4.6-11.5.
    Reply: The tables are correct and the abstract has been edited.
11. TABLE 2:
    a. Abstract says 1.8.
    b. Abstract says 2.6.
    Reply: The tables are correct and the abstract has been edited.

Thanks again!

Lindsey
Dear Dr. Jackson,

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

1. Please note the minor edits and deletions throughout. Please let us know if you disagree with any of these changes.
2. LINE 28: Drs. Spirtos and Pedersen will need to complete our electronic Copyright Transfer Agreement, which was sent to them through Editorial Manager.
3. LINE 50: Add the type of study you conducted to this section.
4. LINE 61: Table 1 says 4.5-11.5. Which is correct?
5. LINE 64: Where is the 0.4 represented in the body text, tables, or figures? Please be sure it is represented somewhere other than the abstract.
6. LINE 65: The data listed for right and left in Table 2 are different. What you have here only applies to the left. Please edit as needed.
7. LINE 66: The data listed here are not consistent with what is stated in Table 2. Please review and edit as needed. Information in the abstract must also be stated elsewhere.
8. LINE 102: Add the type of study you conducted to this section.
9. LINE 199: Please clarify the exact marker that should be same as described in Fig 3 – and line 207, 210, etc
10. TABLE 1: Abstract says 4.6-11.5.
11. TABLE 2:
    a. Abstract says 1.8.
    b. Abstract says 2.6.

Please let me know if you have any questions. Your prompt response to these queries will be appreciated; please respond no later than COB on **Friday, February 1st**.

Sincerely,

-Daniel Mosier

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**Daniel Mosier**
Editorial Assistant
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Ms. Casway,

Thanks! I looked over the PDF and it looks great with the exception of one oversight on my part. The current figure 4 legend reads as follows:

Figure 4. Ureter within ureteral tunnel and ureteral lengths. Superior view of dissected right pelvic sidewall in unembalmed cadaver illustrates relationship of ureter to uterine artery, anterior portion of parametrium (cardinal ligament), and bladder wall. The cardinal ligament has been transected and edges (asterisks) are reflected superior and laterally with tissue clamps. Bladder wall has been transected above trigone. Note connections of bladder to cardinal ligament. Indirect median pelvic ureteral lengths for right side are shown as well as median direct intramural ureter length. AVW, anterior vaginal wall; EIA, external iliac artery; IIA, internal iliac artery; RCIA, right common iliac artery; UO, ureteric orifice.

Median should be changed to mean in both places as highlighted above as we report mean values in table 1. We have also edited figure 4 to reflect this with the correct values and the edited figure is attached. I am so sorry I did not catch this prior to submitting it to you all. The answer to the remaining questions are as follows:

AQ1: Thank you so much for uploading versions of the figures without any text. After working on these figures, we decided that the way you presented the text is much cleaner than our normal journal style. We have chosen to keep these figures in their original format. Thus, no figures were edited.
   Reply: Great, thanks!

AQ2: Note that we switched Figure 4 and 5 to reflect the order in which they appear in the manuscript.
   Reply: Thank you for catching this!

AQ3: What do the arrows in Figures 2 and 4 (was Figure 5) represent?
   Reply: The large arrows in figure 2 and figure 4 represent the direction (left and cephalad) of gentle traction applied to the uterus in order to best visualize the course of the right ureter.

Thank you so much for all your help and please let me know if there is anything else you all need from me!

Thanks!

Lindsey
Good Morning Dr. Jackson,

Your figure legends have been edited, and a PDF of the legends is attached for your review. Please review the legends CAREFULLY for any mistakes. In addition, please see our queries below.

AQ1: Thank you so much for uploading versions of the figures without any text. After working on these figures, we decided that the way you presented the text is much cleaner than our normal journal style. We have chosen to keep these figures in their original format. Thus, no figures were edited.

AQ2: Note that we switched Figure 4 and 5 to reflect the order in which they appear in the manuscript.

AQ3: What do the arrows in Figures 2 and 4 (was Figure 5) represent?

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

To avoid a delay, I would be grateful to receive a reply no later than Thursday, 1/31. Thank you for your help.

Best wishes,

Stephanie Casway, MA
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