OBSTETRICS & GYNECOLOGY

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

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

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

Date: May 07, 2019
To: "Annelise M. Wilhite" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-19-635

RE: Manuscript Number ONG-19-635

Provider Adherence to Surgical Guidelines for Risk Reducing Salpingo-oophorectomy

Dear Dr. Wilhite:

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 May 28, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: I think it's a good review about an important topic. It show us the importance of CME of some important topics that allows us to change the future of our patients lives.

There is an enormous difference between an intervention made by GYNONCs and OBGYNs (and I'm not talking about an special surgery technique)

1. Line 76: There is an age difference indication between RRSO with BRCA 1 -2, I believe its important to mention.

2. Line 136: How many records did you review?

3. The suspected ovarian? Were they offered a RRSO before?

4. Incomplete records were they given the least the chance for RRSO?

5. What happened and why some patients BRCA +, weren't RRSO ?

6. Do you have any suggestion how to improve the adherence from OBGYNs?

Reviewer #2: This is a retrospective cohort study examining compliance with guidelines for risk-reducing salpingo-oophorectomy for patients who are BRCA positive. This is important information for general OB/GYNS to review.

1. Abstract Line 39 typo: should be oophorectomy

2. Introduction: Line 78: SEE-FIM is a term not used in the ACOG guideline, most general OB/GYNs do not reference/use NCCN guidelines so they will not be familiar with the name of this process, but they should be familiar with asking the pathologists to carefully examine and section the entire fallopian tube if the BSO is done for BRCA, does this term appear in the NCCN guideline? I would specify more about the origins of this term. Is this something pathologists will recognize?

3. Introduction: Please add a hypothesis in the last paragraph. I assume it was hypothesized that general OB/GYNs would be less compliant? Please explain more the rationale for the study.

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6. Methods: The methods do not specify that any data was collected about the surgeon and how it was determined whether they were general ob/gyns or gynecologic oncologists.

7. Results: Can you report how many cases per hospital and whether the hospital was community or academic? Did type of hospital influence the results? e.g. would a community pathologist be less likely to perform SEE-FIM compared to an academic pathologist?

8. Results: Figure 2 repeats what is said in Line 150, so either present the Figure or the information in the text but not both.

9. Discussion: What should we be writing on the pathology requisition for these procedures? Please add a recommendation. This is another opportunity to highlight that the surgeon, not the OR nurse, should be filling out the pathology requisition or at least be involved in what is written there.

Reviewer #3: Wilhite et al evaluated provider adherence to recommended surgical protocol for RRBSO to determine whether generalists or gyn oncs more consistently follow evidence based guidelines. The manuscript is succinct and well written.

comments

1. Authors need to state whether any primary peritoneal cancers were identified post BSO, how long was follow up and what general surveillance was. If this is not known it needs to be noted as a weakness. This paper would be much more powerful if we knew that adhering to these guidelines actually resulted in better quality of the actual procedure and patient benefit. so what if a surgeon does not adhere to a guideline if we have no data to prove that non-adherence is dangerous to patients. this needs to be stated.

2. removal of whole tube: 3 cm seems like an arbitrary cut off. Authors should justify

3. Although recommended, pelvic wash has never been shown to increase detection of occult malignancy. Similar to #1 above. and explanation that gyn oncs are more accustomed to performing washes seems rather weak.

4 Of course more occult cancers are diagnosesd when SEE-FIM is followed (line 203). is this increased detection of occult malignancy associated with SEE-FIM in this series?

5. Deciding not to include upper abdominal exploration and retroperitoneal approach/2 cm margin on IP also seems arbitrary. Need the entire story. Upper abdominal exploration can be easily ascertained from op notes. Malacarne et al in a very similar study done between 2006-10 found that biggest variation between gyn oncs and generalists was with the 2cm/retroperitoneal approach aspect of best practices. Mention of prior work in general is extremely light.

STATISTICAL EDITOR'S COMMENTS:

1. lines 49-59: Should cite how many providers in each category were included in the study.

2. Table 1: Need units for age, BMI. Parity can only have integer values. Should cite as median(IQR or range) or as categories and not test as if it were a continuous variable. The frequency of Ashkenhazi is low and there is inadequate power to generalize the NS difference. Also, that comparison should have used Fisher's test, not Chi-square.

3. Table 2: Should include some measure of variability for the mean days from BRCA diagnosis to surgery. The complication rates are low for both cohorts, but there is insufficient power to generalize the NS comparison. Also, that comparison should have used Fisher's test, not Chi-square.

4. Fig 2: Legend should include that the p-values are derived from GEE, not from direct comparisons of the proportions, since that would not account for correlation within provider.

5. General: Although this a large series of BRCA patients, the number of GYNONC providers is relatively small (n = 18), so the results, although statistically significant, might not be generally applicable.

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. 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.

4. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports should not exceed 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

5. 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).

6. 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.

7. 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.

8. 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.

9. 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.

10. The American College of Obstetricians and Gynecologists' (ACOG) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite ACOG documents in your manuscript, be sure the reference you are citing is still current and available. If the reference you are citing has been updated (ie, replaced by a newer version), please ensure that the new version supports whatever statement you are making in your manuscript and then update your reference list accordingly (exceptions could include manuscripts that address items of historical interest). If the reference you are citing has been withdrawn with no clear replacement, please contact the

editorial office for assistance (obgyn@greenjournal.org). In most cases, if an ACOG document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All ACOG documents (eg, Committee Opinions and Practice Bulletins) may be found via the Clinical Guidance & Publications page at https://www.acog.org/Clinical-Guidance-and-Publications/Search-Clinical-Guidance.

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

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

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

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

Again, your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by May 28, 2019, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

The Editors of Obstetrics & Gynecology

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

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COVER LETTER

May 28, 2019

Dear Executive Editor,

Attached along with this cover letter is the electronic version of the manuscript of our original research entitled "**Provider Adherence to Surgical Guidelines for Risk Reducing Salpingo-oophorectomy".** This was a multi-institutional study evaluating provider adherence to the surgical guidelines endorsed by the NCCN and ACOG for risk reducing salpingo-oophorectomy in BRCA mutation carriers. Our data suggest a significant discrepancy in adherence between gynecologic oncologists and obstetrician gynecologists, possibly leading to the higher rate of occult neoplasia detection observed in the cohort of patients undergoing surgery with a gynecologic oncologist. Our results are clinically relevant and highlight a need for improved provider education and communication.

This is the first time that this original work has been submitted for consideration of publication, and it is our intent to submit soley to *Obstetrics and Gynecology*. This work will not be submitted to any other journals until a decision has been made by the editors of *Obstetrics and Gynecology*. This work was not part of a clinical trial or industry-sponsored research. IRB approval was obtained from Fairview Health System/The University of Minnesota and Health Partners. A Data Use Agreement was also obtained so that the data from each site could be combined for analysis.

I, Annelise Wilhite, as the lead author, 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.

Signed by: ___Annelise Wilhite_____

Thank you very much for your consideration of our work. We appreciate the thoughtful comments and questions that we received from the reviewers and the editor. Below you will find the reviewers comments followed by our responses.

Annelise Wilhite, MD

COVER LETTER

REVIEWER COMMENTS:

Reviewer #1: I think it's a good review about an important topic. It show us the importance of CME of some important topics that allows us to change the future of our patients lives.

There is an enormous difference between an intervention made by GYNONCs and OBGYNs (and I'm not talking about an special surgery technique)

1. Line 76: There is an age difference indication between RRSO with BRCA 1 -2, I believe its important to mention.

Thank you for pointing this out. That is an important distinction, and we have added this in our introduction (lines 80-81).

2. Line 136: How many records did you review?

We reviewed a total of 2,446 charts (as noted in Figure A, 1,947 from were identified and reviewed from ICD 9 and 10 codes and 499 were identified and reviewed from the regional genetic data base). We cast a very wide net in order to not miss any cases. The vast majority of records were not eligible for inclusion. We did not include this total number in the manuscript because we do not feel it adds value to the outcome of interest.

3. The suspected ovarian? Were they offered a RRSO before?

This is an interesting question but was outside the scope of this study. We did not address whether or not those with suspected ovarian cancer were offered RRSO. We excluded those patients with a mass and elevated Ca-125, as it would have been considered more of a diagnostic or therapeutic procedure as opposed to risk-reducing. Although it was not one of the measures that we collected data for specifically, many of the patients with ovarian cancer were diagnosed with a BRCA mutation after their cancer diagnosis, thus they did not receive counseling on a risk reducing salpingo-oophorectomy.

4. Incomplete records were they given the least the chance for RRSO

Given the limitations of the medical record and the retrospective nature of this study, we were unable to determine if all of the patients with incomplete records were ultimately offered RRSO. For example, we identified patients who had a mutation detected, but we were unable to find further records of any subsequent OBGYN or GYN Oncology surgical consultation. If they did not meet inclusion criteria for another reason, this was noted (Figure 1).

5. What happened and why some patients BRCA +, weren't RRSO?

We feel this is a very important clinical question, too. Although many patients who had not undergone RRSO were younger than the recommended age, reasons for deferring RRSO were not specifically address for this study. We are doing a separate study addressing this topic.

6. Do you have any suggestion how to improve the adherence from OBGYNs?

Thank you for bringing this up. We feel there is substantial room for improvement in terms of education and awareness about this issue. For example, this would be a great topic for CME for general OBGYNs. Referral to a subspecialist or a hospital that has providers who routinely do these procedures may be warranted to ensure patients are receiving more complete guideline-based care. For those aware of the guidelines, these results highlight the importance of communication and documentation. We have added more to our discussion to specifically addresses this question (lines 227-229).

Reviewer #2: This is a retrospective cohort study examining compliance with guidelines for risk-reducing salpingo-oophorectomy for patients who are BRCA positive. This is important information for general OB/GYNS to review.

1. Abstract Line 39 typo: should be oophorectomy.

Thank very much for catching this. This has been addressed (line 41).

2. Introduction: Line 78: SEE-FIM is a term not used in the ACOG guideline, most general OB/GYNs do not reference/use NCCN guidelines so they will not be familiar with the name of this process, but they should be familiar with asking the pathologists to carefully examine and section the entire fallopian tube if the BSO is done for BRCA, does this term appear in the NCCN guideline? I would specify more about the origins of this term. Is this something pathologists will recognize?

Thank you for this question. You are correct that this technical term “SEE-FIM” is not used in the ACOG guidelines, although serial sectioning with microscopic examination of the entire specimen is recommended and this is essentially synonymous with SEE-FIM. We have updated our manuscript to address this subtlety (lines 83-86, 91-95).

3. Introduction: Please add a hypothesis in the last paragraph. I assume it was hypothesized that general OB/GYNs would be less compliant? Please explain more the rationale for the study.

Thank you for bringing this up. The idea for this study was initially for assessment of institutional compliance and quality improvement. We did predict that GYNONCs would be more compliant since they do more of these procedures and their careers are focused on cancer and cancer prevention, but given the retrospective nature of this study (and attempts to include all eligible patients) we did not use a power calculation (see below), and therefore, although we had a clinical suspicion, we did not have a formal hypothesis (h0, h1) and thus we respectfully decline adding a formal hypothesis to the introduction. If the journal feels this is statistically appropriate, we are willing to add it in.

4. Methods: I don't see a sample size calculation or any reason why the years 2011-2017 were chosen.

COVER LETTER

We appreciate the suggestion of an ad hoc power analysis. We understand that this is done at times, however, based on consultation with our statistics team, we feel that this does not add to the statistics already presented and is not appropriate for this retrospective cohort study. Please see the reference below that explains further our view on this matter [1]. If the journal does feel this is statistically appropriate, we are willing to add it in.

The year 2011 was chosen primarily because the recommendation for serial sectioning and microscopic examination of the entire specimen was published in the initial 2009 version of the ACOG practice bulletin, so we felt that 2011 provided enough time for this to be integrated in practice. We began this study in 2018, so we sought to include all patients up until the time of study initiation.

1. JM, H. and H. DM, *The Abuse of Power: The Pervasive Fallacy of Power Calculations for Data Analysis.* The American Statistician, 2001. **55**(1): p. 6.

5. Methods: Line 125, were the one-half of the original specimens selected for the study pathologist to re-review identified randomly? How were these chosen?

This is a good question, and yes, the slides were selected at random from our final inclusion participant list to include specimens from multiple hospitals.

6. Methods: The methods do not specify that any data was collected about the surgeon and how it was determined whether they were general ob/gyns or gynecologic oncologists.

Provider specialty was determined either from the electronic medical record or through the website of the providers' employer. We have added this to the manuscript (lines 139-141).

7. Results: Can you report how many cases per hospital and whether the hospital was community or academic? Did type of hospital influence the results? e.g. would a community pathologist be less likely to perform SEE-FIM compared to an academic pathologist?

This is a great point, thank you for bringing it up. Six of the OBGYN (4.6%) cases and 82 (51%) of the GYN ONCs were performed at the University hospital. ($p < 0.01$). SEE-FIM was followed in 87 (99%) of cases performed at the University hospital and 176 cases (87%) performed at non-University hospitals ($p<0.01$). Six of the 11 cases of occult neoplasm (55%) were diagnosed at the University hospital ($p= 0.10$). Unfortunately, the health care systems included in this study make it difficult to make these binary distinctions. For example, many academic providers (particular GYN-ONCs) provide care at both the University/academic center as well as community practices. Many of the "community" OBGYNs hold academic appointments within the academic medical center. Some of the hospitals within a particular system employ primarily academic pathologists, others community pathologists. Some specialize in gynecology while others do not. We felt that given these overlapping variables, a subgroup analysis would be difficult to interpret. (lines 181-185, 239-241)

8. Results: Figure 2 repeats what is said in Line 150, so either present the Figure or the information in the text but not both.

COVER LETTER

This line really summarizes the primary findings in the study. We do feel it is important to mention in the body of the result section. We have removed the OR from the text and included this in the figure only to help make the text more succinct. We hope this will be acceptable to the reviewers (lines 163-168).

9. Discussion: What should we be writing on the pathology requisition for these procedures? Please add a recommendation.

Thank you for this question and suggestion. We have added recommendations to the discussion (lines 231-232).

Reviewer #3: Wilhite et al evaluated provider adherence to recommended surgical protocol for RRBSO to determine whether generalists or gyn oncs more consistently follow evidence-based guidelines. The manuscript is succinct and well written.

comments

1. Authors need to state whether any primary peritoneal cancers were identified post BSO, how long was follow up and what general surveillance was. If this is not known it needs to be noted as a weakness. This paper would be much more powerful if we knew that adhering to these guidelines actually resulted in better quality of the actual procedure and patient benefit. so what if a surgeon does not adhere to a guideline if we have no data to prove that non-adherence is dangerous to patients. this needs to be stated.

Thank you for bringing up this valuable point. Long term follow-up was not available for this study, given the time period of 2011-2017 and we agree that ultimately the most important outcome is survival and cancer incidence.

We have added median follow up to the results (lines 179-189) and there was no evidence of primary peritoneal cancer to date (line 179-180). We do have plans to follow these patients long term to assess cancer risk. We feel that diagnosing occult malignancy is an important reason to follow the recommendations, and we speculate that if occult malignancy is missed, patients may miss the opportunity for further staging or follow up (lines 248-250).

2. removal of whole tube: 3 cm seems like an arbitrary cut off. Authors should justify.

Thank you for this suggestion. We chose 3cm as a cut off because most fallopian tubes (not including the fimbriae and cornual portion of the tube) are between 7-12 cm, with approximately 1.5 cm of the tube located in the cornua (and therefore cannot be resected) and about 2cm of fimbriae. Thus, we felt that the lower limit of normal is 7cm-2cm-1.5cm = 3.5cm. We then allowed a 0.5cm margin of error. We consulted our gynecologic pathology team for these recommendations, yet we recognize this is still arbitrary. We have changed the wording to be 5cm including the fimbriated end. Notably, there was very high adherence to resecting the "whole tube" in both cohorts. We have added this to the methods and mentioned it as a limitation in the discussion (lines 130-132, 243-246).

3. Although recommended, pelvic wash has never been shown to increase detection of occult

malignancy. Similar to #1 above. and explanation that gyn oncs are more accustomed to performing washes seems rather weak.

We appreciate this feedback. While the clinical utility of pelvic washings has been questioned, it remains a recommendation, and has been associated with occult malignancy and thus could have potential prognostic value. The goal of this study was to assess compliance with recommendations, although we recognize that guidelines may evolve over time based on our knowledge of cancer detection and prevention.

4 Of course more occult cancers are diagnosesd when SEE-FIM is followed (line 203). is this increased detection of occult malignancy associated with SEE-FIM in this series?

Thank you for this feedback. Increased detection of malignancy is associated with SEE-FIM in this series (rates of detection are higher in the GYN ONC group compared to OBGYN and rates of SEE-FIM are higher in the GYN ONC group compared to OBGYN) (lines 165, 175-176). Notably, in all cases of neoplastic disease, SEE-FIM was utilized (line 173-174).

5. Deciding not to include upper abdominal exploration and retroperitoneal approach/2 cm margin on IP also seems arbitrary. Need the entire story. Upper abdominal exploration can be easily ascertained from op notes. Malacarne et al in a very similar study done between 2006-10 found that biggest variation between gyn oncs and generalists was with the 2cm/retroperitoneal approach aspect of best practices. Mention of prior work in general is extremely light.

Thank you for making this point. Ideally, we would like to include these variables as well in order to assess entire protocol adherence. However, due to the retrospective nature of this study, we felt that it was most important to include data that was as objective as possible in order to fairly assess compliance. Collection of washings, SEE-FIM, and length of fallopian tube are all objective measures that are detailed in a pathology report. Unfortunately, our pathologists do not routinely comment on the IP margin. Although we could potentially infer this based on reading the operative report, we were concerned about too much potential bias and thus we did not include this variable.

Regarding upper abdominal survey, although this is frequently mentioned in the operative report, we also had concerns that the operative report may not be a fair assessment of what was actually done (especially the extent of survey). Again, we were concerned about introducing too much bias and thus did not include this variable as well. We recognize this is a weakness of the paper and have added this to our discussion (lines 243-246).

STATISTICAL EDITOR'S COMMENTS:

1. lines 49-59: Should cite how many providers in each category were included in the study.

We agree this is an important point. This is stated in the second line of the results. There were 75 OBGYNs and 18 GYNONCs (lines 51-52, 150-151).

2. Table 1: Need units for age, BMI. Parity can only have integer values. Should cite as

median(IQR or range) or as categories and not test as if it were a continuous variable. The frequency of Ashkenhazi is low and there is inadequate power to generalize the NS difference. Also, that comparison should have used Fisher's test, not Chi-square. (*fischer's was used)

Thank you for this valuable feedback. We have added the units for BMI and age, and adjusted parity to integer values. We have adjusted the race/ethnicity cohort to include Ashkenazi, and added that p-value was calculated as white vs. non-white. This has been added to table 2.

3. Table 2: Should include some measure of variability for the mean days from BRCA diagnosis to surgery. The complication rates are low for both cohorts, but there is insufficient power to generalize the NS comparison. Also, that comparison should have used Fisher's test, not Chi-square.

Thank you for this feedback. We have added the standard deviation to mean days (line 334, table 2). The p value for the complication rates was determined by a generalized linear model.

4. Fig 2: Legend should include that the p-values are derived from GEE, not from direct comparisons of the proportions, since that would not account for correlation within provider.

We appreciate you pointing this out. Thank you. We have added that the P values are derived from a generalized linear model (lines 360-361).

5. General: Although this a large series of BRCA patients, the number of GYNONC providers is relatively small (n = 18), so the results, although statistically significant might not be generally applicable.

We acknowledge this limitation. However, given that this represents the majority of GYN Oncology providers in this region and also represents both academic, private practice, and hybrid practices, we do feel that there is general applicability to our findings. Gathering this level of detail from a national database (that may capture more GYN ONC providers) would be exceedingly challenging, if not impossible. We therefore hope that our data – although somewhat limited in number of providers - can be helpful in improving the surgical care of women at high risk for developing ovarian cancer.

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:
OPT-IN: Yes, please 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. Acknowledged.

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. 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. Acknowledged.

4. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports should not exceed 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references. Acknowledged.

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

* All financial support of the study must be acknowledged.
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