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

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

*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.
RE: Manuscript Number ONG-18-1136

EXTERNAL USE OF SURGICEL IN TREATMENT OF LABIAL AGGLUTINATION IN POSTMENOPAUSAL WOMEN

Dear Dr. Wyman:

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 Aug 03, 2018, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1:

Thank you for the opportunity to review your manuscript: "EXTERNAL USE OF SURGICEL IN TREATMENT OF LABIAL AGGLUTINATION IN POSTMENOPAUSAL WOMEN." I think this research is timely, innovative, and can definitely add to the existing literature, expanding our resources to treat this often challenging disease.

1) There are other topical forms of adhesion reducers on the market (Sepraspray, Seprafilm slurry), which might be able to applied in office and, even, at home for intervals. Is there any existing data exploring the utility of such items in treating lichen diseases? What are your thoughts on that possibility and mentioning it in "future directions" if applicable?

2) It was a little unclear if the 2nd case continued estrogen +/- topical steroid post intervention. (I could just be missing it). Would you please clarify if that was the case? The 1st case sounds like she was advised to continue estrogen but, perhaps, wasn't very compliant? I just wanted to clarify, as it would help readers, who may want to apply these techniques in their own patient populations, know if this should be continued to achieve sustained results.

3) Can you please also, briefly, explain in your manuscript why you chose these particular patients? It may have been because they were the 1st to present with needed surgical intervention for lichen, but it would be good to clarify if there was any other selection process.

Reviewer #2:

1. Summary: This is a case report of two cases of lichen sclerosus requiring surgical management of labial agglutination. The authors report using Surgicel, an oxidizing regenerating cellulose agent, to prevent recurrence of agglutination.

2. Novelty: This represents a novel approach to preventing recurrence of labial agglutination after surgical management of lichen sclerosis.

3. Methodology: This is an interesting and well-written case report that follows the format as described in the information for authors. I think that it could be developed a little bit to be more informative:

   a. Line 95 (Teaching point #1): I recommend adding a comment about recurrence after surgical management to better describe the main focus of your case report.
b. Line 130-136: I recommend describing more detail on your decision to try using Surgicel. For example, is there a difference between Interceed and Surgicel besides it being in a gauze form? You comment that Interceed is an adhesion barrier, but Surgicel is a hemostatic agent. Why did you then choose to use Surgicel compared to Interceed? Similarly, what is the proposed mechanism of action, and has this been used externally (versus intraperitoneal) to treat other skin conditions? How did you decide on your technique to attach it with suture and remove it after a few days?

c. Line 160-162 and 179-181: I think it would be helpful to define in the introduction how likely recurrence is, and the typical time to recurrence after surgical management of lichen sclerosus. In other words, please justify your follow-up timepoint of 12-18 months.

d. Line 216-217: Are there any other reported treatments that have been tried (including treatments tried and failed) to prevent recurrence of agglutination? How effective is vaginal estrogen and clobetasol for preventing recurrence after surgery? I know we cannot compare without a trial, but in order to know if this is really a novel and potentially effective treatment, it would be helpful to try and compare it somehow to what we know about the outcomes of current treatment options and if the result was better than what you would have otherwise expected when using standard treatment after surgery.

4. Significance: I have recently surgically managed a few cases of refractory lichen sclerosus and urinary obstruction or near-obstruction and I think that most of us dread these cases because of the fear of recurrence and worsening of the disease. There is currently a paucity of data to guide therapy to prevent recurrence and this case report presents a novel approach to treatment that could be further studied in comparative trials.

5. Presentation: This was a well-written case report. It is clear, concise, and has well-defined teaching points. Pictures and longer follow-up time would be a great addition to this piece.
Thank you for the opportunity to review your work.

Reviewer #3:

Overall this is a good case report about a new approach to a clinical condition very relevant to practicing Ob/gyns. Some things can make the manuscript stronger:

1. The teaching points should better match the manuscript. The manuscript is about the success of surgical as an adjunct to survival management.

2. Estrogen was still used for post-surgical management and that is important enough to perhaps be a teaching point.

3. How is the need for biopsy (Point 3) related to the case? This is just a general teaching point. Focus the teaching points on points specific to the cases you present.

EDITOR COMMENTS:

1. Thank you for your submission to Obstetrics & Gynecology. In addition to the comments from the reviewers above, you are being sent a notated PDF that contains the Editor’s specific comments. Please review and consider the comments in this file prior to submitting your revised manuscript. These comments should be included in your point-by-point response cover letter.

***The notated PDF is uploaded to this submission's record in Editorial Manager. If you cannot locate the file, contact Katie McDermott and she will send it by email – kmcdermott@greenjournal.org.***

2. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter, 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.

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. A signed consent form must be obtained from each patient described in a case report. In all cases (photograph or video) in which a human image is shown (in part or whole), written consent must also be obtained. A sample form is available online at http://edmgr.ovid.com/ong/accounts/release.pdf. It is preferable to give the patient the opportunity to read the manuscript. Please state in the cover letter with your submitted manuscript that you have obtained a signed consent form and that this form will be filed with your records. Unless the editorial office requests that you do so, please do not submit the signed form to the journal.

5. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology will be transitioning as much as possible to use of the reVITALize definitions, and we encourage authors to familiarize themselves with them. The obstetric data definitions are available at http://links.lww.com/AOG/A515, and the gynecology data definitions are available at http://links.lww.com/AOG/A935.

6. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Case Reports should not exceed 8 typed, double-spaced pages (2,000 words); Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, tables, boxes, figure legends, and appendixes). Please limit your Introduction to 250 words and your Discussion to 750 words.

7. Specific rules govern the use of acknowledgments in the journal. Please edit your acknowledgments or provide more information in accordance with 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 signature on the journal's author agreement 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).

8. Provide a short title of no more than 45 characters (40 characters for case reports), including spaces, for use as a running foot.

9. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

In addition, the abstract length should follow journal guidelines. The word limits for different article types are as follows: Original Research articles, 300 words; Reviews, 300 words; Case Reports, 125 words; Current Commentary articles, 250 words; Clinical Practice and Quality, 300 words; Procedures and Instruments, 200 words. Please provide a word count.

10. Only standard abbreviations and acronyms are allowed. A selected list is available online at http://edmgr.ovid.com/ong/accounts/abbreviations.pdf. Abbreviations and acronyms cannot be used in the title or précis. Abbreviations and acronyms must be spelled out the first time they are used in the abstract and again in the body of the manuscript.

11. The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.
12. The American College of Obstetricians and Gynecologists' (College) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite College 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. 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 a College document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All College documents (eg, Committee Opinions and Practice Bulletins) may be found via the Resources and Publications page at http://www.acog.org/Resources-And-Publications.

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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, that each author has given approval to the final form of the revision, and that the agreement form signed by each author and submitted with the initial version remains valid.

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 Aug 03, 2018, 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

If you would like your personal information to be removed from the database, please contact the publication office.
Dear Editors and Reviewers of Obstetrics and Gynecology,

Thank you very much for your thoughtful review and consideration for acceptance of our manuscript into your prestigious journal. We have addressed all requested revisions by the Editors and have addressed all recommendations by the Reviewers as listed below to the best of our ability. Please let us know if we can revise or clarify and further questions or concerns. Thank you again for your dedicated time to review our manuscript.

**EDITOR COMMENTS:**

**Editor Comment #1 (line 48): Add the word “to”**

Response #1: Thank you very much for bringing this grammatical error to our attention. We have corrected the error within the text.

*Modified Text: The use of an oxidizing regenerating cellulose agent may create an effective barrier to recurrence of labial agglutination in postmenopausal women.*

**Editor Comment #2 (line 94): your teaching points don't relate to recurrence of agglutination nor its treatment**

Response #2: Thank you very much for your clarification. We have restructured the case report to clearly address our main objective to report on the use of external use of surgical in treatment of labial agglutination in postmenopausal women. We have also revised our teaching points to reflect our learning objective.

*Modified text:*

**Teaching points:**

1. Vaginal atrophy and vulvar lichen sclerosus are common etiologies for chronic vulvovaginal pruritus and labial agglutination in both prepubertal and postmenopausal women

2. Surgical management of labial agglutination should be reserved for patients with disease refractory to medical management or with obstructive urinary symptoms

3. Refractory or recurrent labial agglutination can result in symptomatic architectural changes of the vulvovaginal anatomy
**Editor Comment #3 (line 116):** From reading your abstract and teaching points and now the introduction of the paper, I think it’s important to focus things a bit. You start your intro and your teaching points about lichen sclerosis but your paper is about recurrent agglutination. Realizing that your two patients had LS as an underlying etiology of the agglutination, do you think the treatment would be effective for other causes of agglutination? I would recommend leading your intro about agglutination, underlying etiologies, treatments and recurrent risks. Then in last paragraph, having included LS as a common cause in older women particularly, indicate that it is in this setting you explored surgicel as a treatment option.

**Response #3:** Thank you very much for your recommendations and your thoughtful review. We appreciate your insightfulness and examples to improve our manuscript. We agree with the need to focus the introduction and start of the teaching points to labial agglutination and the underlying etiology of potential causes and then focus on our specific patients. We have addressed and applied your recommendations to the best of our ability and have cut down the word count of the introduction to <250 words as requested also in the revision.

**Modified Text:**

Vulvovaginal diseases affect women of all ages. Vaginal atrophy and vulvar lichen sclerosus are common etiologies for chronic vulvovaginal pruritus and labial agglutination in both prepubertal and postmenopausal women [1].

Labial agglutination from chronic irritation can lead to vulvovaginal pain, dysuria, dyspareunia, and urinary incontinence or urinary retention if obstruction occurs [1, 14]. First line treatment includes topical low-dose estrogen cream to address the underlying vaginal atrophy along with topical use of a high-potency topical steroid cream, clobetasol propionate, to address underlying dermatosis if present [15]. Surgical intervention should be reserved for only refractory disease to medical management or in the setting of acute urinary retention. Surgical separation of tissue can often result in recurrence of adhesions and increased scarring of the tissue.

Oxidizing regenerating cellulose agents (Interceed, Johnson & Johnson, Arlington, TX), has been described to minimize intra-abdominal adhesions when placed intra-operatively for laparoscopic or open procedures [4]. Surgicel (Johnson & Johnson, Arlington, TX) is another oxidizing regenerating cellulose agent in a gauze form often used as a hemostatic agent. Breech et al described the use of Surgicel, on external surgical sites for prevention of recurrent of clitoral and labial adhesions in peripubertal girls with lichen sclerosus with optimal outcomes at one year postop [2].

We present two cases of postmenopausal women with severely symptomatic labial agglutination from refractory lichen sclerosus. Both patients required surgical intervention and the application of Surgicel externally to the surgical field after manual separation of labial agglutination.

**Editor comment #4 (line 128):** any data on how often recurrence occurs? Obviously an important point since your cases illustrate attempts to prevent recurrence.

**Response #4:** Thank you very much for this recommendation. We have reviewed the literature and are unable to find any papers on the rates of recurrence. We did find papers to support what we have listed in our manuscript about the risk of recurrence with surgery and how only surgery should be selected to
patients who have refractory disease to medical management. "The high recurrence rate of all surgical modalities makes surgical treatment suitable only for patients who failed to respond to multiple medical treatments such as topical high potent steroid ointments, testosterone, and retinoids." It's the only paper that has spoken about what we need. Also, none of the more recent reviews have looked at recurrence rates from surgery.


**Editor comment #5 (line 135):** comma not needed

**Response #5:** Thank you again for bringing this grammatical error to our attention. We have corrected the error within the text

**Editor comment #6 (line 138):** who were treated with...

**Response #6:** Thank you again for bringing this grammatical error to our attention. We have corrected the error within the text

*Modified Text:* We present two cases of postmenopausal women with severely symptomatic labial agglutination from refractory lichen sclerosus. Both patients required surgical intervention and the application of Surgicel externally to the surgical field after manual separation of labial agglutination.

**Editor Comment #7 (line142):** Did she have lichen sclerosis too? If not, makes it all the more important to remove the focus on LS from your intro, teaching points.

**Response #7:** Thank you for question and clarification. Yes, this patient has had a long history of refractory lichen sclerosus. It was an error to miss the opportunity to clearly make this apparent. We have revised the text to reflect her relevant past medical history

*Modified text:* She had a prior history of severe vaginal atrophy and lichen sclerosis resulting in symptomatic architectural changes of her vulvovaginal anatomy and labial agglutination almost to complete fusion requiring surgical lysis twice within the last ten years.

**Editor comment #8 (line 144):** delete "in"

**Response #8:** Thank you again for bringing this grammatical error to our attention. We have corrected the error within the text
She began to notice changes in her urinary stream shortly after stopping use of estrogen cream therapy and now had difficulty emptying her bladder. She opted for surgical intervention of labial agglutination to treat her voiding dysfunction. She was asked to apply estrogen cream twice daily until surgery, xxx weeks later. (important to give time frame as you needed some time for the estrogen to work).

After the labial and clitoral adhesions were sharply and bluntly lysed, Surgicel was cut.....

Response #9: Thank you for your recommendation. We have applied your recommendations to the modified text below in the manuscript:

Modified Text: She began to notice changes in her urinary stream shortly after stopping the use of estrogen cream therapy and now presented with difficulty emptying her bladder and constant urinary leakage. She opted for surgical intervention of labial agglutination to treat her bladder symptoms. She was asked to apply estrogen cream twice daily until surgery that was scheduled within four weeks secondary to her symptomatic urinary incontinence.

After the labial and clitoral adhesions were sharply and bluntly lysed, Surgicel was cut into two separate rectangular pieces and sized appropriately to lay flat along the dissected medial and lateral surface of each separated labial minora. Estrogen cream was applied to the tissue and the Surgicel was then sutured in place with interrupted 4-0 biosyn in a four corner pattern for each side. Two sutures were placed in the midline to ensure the gauze was lying flat against the tissue.

Response #10: Thank you again for bringing this grammatical error to our attention. We have revised the text to reflect your recommendation.

Response #11: Thank you very much for your recommendation. We have revised the manuscript to reflect your recommendations and requests.

Modified text: A 71-year-old with a history of lichen sclerosis exacerbated from tissue trauma by a D&C performed a year ago for endometrial lining sampling presented to clinic. She continued topical clobetasol and estrogen therapy after her procedure, but noted symptoms of irritation persisted. She was now experiencing daily urinary leakage and voiding dysfunction secondary to labial agglutination and fusion at the posterior aspect of her introitus. On physical exam, the introitus was noted to be completely obliterated posteriorly with only a 7 mm opening anterior at the urethral meatus. She was counseled on
management options and elected for surgical intervention secondary to her urinary leakage.

The agglutination was lysed, estrogen cream was applied, and Surgicel was then sutured in place to both the medial and lateral aspects of the dissected tissue in a rectangular fashion with interrupted 3-0 biosyn. At two weeks post op only two sutures remained which were removed. At one year postop there was no noted recurrence of the agglutination and she was able to undergo endovaginal ultrasound for re-evaluation of postmenopausal bleeding where a polyp was noted and removed.

**Editor comment #12 (line 183):** Don't repeat from the introduction. Again, you focus on LS not agglutination in the beginning of your introduction. Focus on the point of your paper first.

**Response #12:** Thank you again for your recommendations. We have revised the discussion to your request.

**Modified text:**

Recurrent or refractory labial agglutination can result in architectural changes of the vulvovaginal anatomy resulting in severely symptomatic urogenital symptoms. In this case report, one patient presented with recurrence of her disease after treatment with both medical and surgical interventions, while the second patient presented with new onset of refractory disease to medical management after tissue trauma. Both patients presented with architectural changes of the vulvovaginal anatomy resulting in symptomatic voiding dysfunction and urinary incontinence from post void dribbling of trapped urine in the vagina.

Vaginal atrophy and vulvar lichen sclerosus are common etiologies for chronic vulvovaginal pruritus and labial agglutination in both prepubertal and postmenopausal women. Both patients in this case report were postmenopausal and diagnosed with lichen sclerosus. Lichen sclerosus (LS) is a chronic inflammatory disease [1,3].......
possibility and mentioning it in "future directions" if applicable?

**Response:** Thank you so much for this excellent idea. We have added the below final paragraph to our manuscript. Thank you again for your thoughtfulness in the review

**Modified text**

*Future directions include further investigation of the recurrence rate of labial agglutination with the use of Surgicel as an adhesive barrier along with future studies designed to compare with control group of patient with no adhesion barriers and evaluation of other topical forms of adhesion reducers (Sepraspray, Seprafilm slurry) which may be able to applied after office procedure of manual separation.*

**Comment #2:** It was a little unclear if the 2nd case continued estrogen +/- topical steroid post intervention. (I could just be missing it). Would you please clarify if that was the case? The 1st case sounds like she was advised to continue estrogen but, perhaps, wasn't very compliant? I just wanted to clarify, as it would help readers, who may want to apply these techniques in their own patient populations, know if this should be continued to achieve sustained results.

**Response:** Thank you very much for this clarification. Yes, we recommended the patient to continue topical estrogen therapy.

**Comment #3:** Can you please also, briefly, explain in your manuscript why you chose these particular patients? It may have been because they were the 1st to present with needed surgical intervention for lichen, but it would be good to clarify if there was any other selection process.

**Response:** Thank you very much for your clarification. We added this conclusion paragraph to the manuscript to help clarify we choose these two patients for the use of Surgicel.

**Modified Text:**

*In conclusion, both patients presented with a long history of lichen sclerosus, irritative urogenital symptoms, along with persistent and worsening labial agglutination resulting in symptomatic urinary incontinence secondary to entrapment of urine within vaginal canal. In the first patient this was her third and most severe presentation of labial agglutination and the second patient had occurrence of the agglutination after trauma to the posterior fourchette. Because of their history, the option of applying Surgicel was discussed with both patients in attempt to prevent re-occurrence labial agglutination.*
Reviewer #2:

1. Summary: This is a case report of two cases of lichen sclerosus requiring surgical management of labial agglutination. The authors report using Surgicel, an oxidizing regenerating cellulose agent, to prevent recurrence of agglutination.

2. Novelty: This represents a novel approach to preventing recurrence of labial agglutination after surgical management of lichen sclerosis.

3. Methodology: This is an interesting and well-written case report that follows the format as described in the information for authors. I think that it could be developed a little bit to be more informative:

   a. Line 95 (Teaching point #1): I recommend adding a comment about recurrence after surgical management to better describe the main focus of your case report.
      a. **Response:** Thank you very much for your review and recommendation. Based on your insightful recommendation and the recommendations of other reviewers and the editor, we have changed our teaching points to better address and focus the report. The revised text is below:
      
      **Modified text:**
      
      **Teaching points:**
      1. Vaginal atrophy and vulvar lichen sclerosus are common etiologies for chronic vulvovaginal pruritus and labial agglutination in both prepubertal and postmenopausal women
      2. Surgical management of labial agglutination should be reserved for patients with disease refractory to medical management or with obstructive urinary symptoms
      3. Refractory or recurrent labial agglutination can result in symptomatic architectural changes of the vulvovaginal anatomy

   b. Line 130-136: I recommend describing more detail on your decision to try using Surgicel. For example, is there a difference between Interceed and Surgicel besides it being in a gauze form? You comment that Interceed is an adhesion barrier, but Surgicel is a hemostatic agent. Why did you then choose to use Surgicel compared to Interceed? Similarly, what is the proposed mechanism of action, and has this been used externally (versus intraperitoneal) to treat other skin conditions? How did you decide on your technique to attach it with suture and remove it after a few days?
      a. **Response:** Thank you very much for your thoughtful suggestion. We specifically choose Surgicel secondary to the success reported in the published case report by Breech et al [2] with the use of Surgicel applied externally to surgical beds with suture intraoperatively to peripubertal girls with refractory lichen sclerosus.
c. Line 160-162 and 179-181: I think it would be helpful to define in the introduction how likely recurrence is, and the typical time to recurrence after surgical management of lichen sclerosus. In other words, please justify your follow-up timepoint of 12-18 months.
   a. **Response:** Thank you very much for your recommendation. We have taken your recommendations and added the modified text

d. Line 216-217: Are there any other reported treatments that have been tried (including treatments tried and failed) to prevent recurrence of agglutination? How effective is vaginal estrogen and clobetasol for preventing recurrence after surgery? I know we cannot compare without a trial, but in order to know if this is really a novel and potentially effective treatment, it would be helpful to try and compare it somehow to what we know about the outcomes of current treatment options and if the result was better than what you would have otherwise expected when using standard treatment after surgery.
   a. **Response:** thank you very much for bringing up this important point. We are unaware of any pertinent studies to compare outcomes from all reported treatments to specifically decrease the risk of recurrence of symptomatic labial agglutination, but we are interested as a group to explore this topic in research and believe we will be able to provide some more outcomes in the future to contribute to the literature. We added the below paragraph to the manuscript to reflect this subject

   **Modified Text:**

   Future directions include further investigation of the recurrence rate of labial agglutination with the use of Surgicel as an adhesive barrier along with future studies designed to compare with control group of patient with no adhesion barriers and evaluation of other topical forms of adhesion reducers (Sepraspray, Seprafilm slurry) which may be able to applied after office procedure of manual separation.

4. Significance: I have recently surgically managed a few cases of refractory lichen sclerosus and urinary obstruction or near-obstruction and I think that most of us dread these cases because of the fear of recurrence and worsening of the disease. There is currently a paucity of data to guide therapy to prevent recurrence and this case report presents a novel approach to treatment that could be further studied in comparative trials.

5. Presentation: This was a well-written case report. It is clear, concise, and has well-defined teaching points. Pictures and longer follow-up time would be a great addition to this piece.

Thank you for the opportunity to review your work.
Reviewer #3:

Overall this is a good case report about a new approach to a clinical condition very relevant to practicing Ob/gyns.

Some things can make the manuscript stronger:

1. The teaching points should better match the manuscript. The manuscript is about the success of surgical as an adjunct to survival management.

2. Estrogen was still used for post-surgical management and that is important enough to perhaps be a teaching point.

3. How is the need for biopsy (Point 3) related to the case? This is just a general teaching point. Focus the teaching points on points specific to the cases you present.

Response: Thank you very much for your recommendations and thoughtful review of our manuscript. Based on your recommendations and the recommendations of other reviewers, we have changed our teaching points to better address and focus the report. The revised text is below:

Modified text:

Teaching points:

1. Vaginal atrophy and vulvar lichen sclerosus are common etiologies for chronic vulvovaginal pruritus and labial agglutination in both prepubertal and postmenopausal women

2. Surgical management of labial agglutination should be reserved for patients with disease refractory to medical management or with obstructive urinary symptoms

3. Refractory or recurrent labial agglutination can result in symptomatic architectural changes of the vulvovaginal anatomy

We, as the authors, intent to submit solely to Obstetrics & Gynecology and verify that the manuscript is not under consideration elsewhere, and we will not submit elsewhere until a final decision is made by the Editors of Obstetrics & Gynecology. I, Allison Wyman, declare transparency as the lead author. We obtained Institutional review board (IRB) exemption for this
project and written consent was obtained from the patients for presentation of the cases.

Please let me know if there are any further questions or concerns, Again, thank you very much for your review and consideration,

Sincerely,
Allison Wyman, MD

awyman@health.usf.edu
+14402272712 cell number
Division of Female Pelvic Medicine and Reconstructive Surgery, Department of Obstetrics and Gynecology, University of South Florida, STC Building, 6th Floor, 2 Tampa General Circle, Tampa, FL, 33606
Dear Stephanie,

Thank you very much for your email and the opportunity to revise the manuscript. I attached the revised manuscript with tracked changes and replies to the comments, along with the below point-by-point response. Please let me know if you need any other revisions or changes.

Thank you again very much for your time and help.

Sincerely,

Allison Wyman, MD

1. The journal avoids using brand names everywhere but in the body text. Okay to use “Oxidizing Regenerating Cellulose Agent” as the generic term? This has been replaced throughout. (line 4)
   
   Response - Yes this is great. Thank you for adjusting and changing throughout for me.

2. “Hemostatic Agent” okay here? (line 50)
   
   Response – It is perfect! Thank you.

3. None of your teaching points has anything to do w/ recurrent agglutination or use of surgical. As this is the topic of your paper, at least one of them should, preferably the first one. (line 83)
   
   Response - Thank you so much for this suggestion, I have adjusting and changed the teaching points as seen here. We were unable to find any data within the literature on the recurrence rate of labial agglutination in postmenopausal women. Only some case series for prepubertal.

   Modified Text:

   1. Surgical separation of labial agglutination in postmenopausal women can result in
recurrence of labial adhesions and scarring of the tissue

2. Refractory or recurrent labial agglutination in postmenopausal women is currently unknown and can result in symptomatic architectural changes of the vulvovaginal anatomy

3. Surgical management of labial agglutination should be reserved for patients with disease refractory to medical management or with obstructive urinary symptoms

7 Any references regarding the rates of recurrence? (line 105)
   Response: We were unable to find any data within the literature on the recurrence rate of labial agglutination in postmenopausal women. Only some case series for prepubertal

8 This is plural but you’ve named one. If its an example of several, please indicate that in the parentheses [like e.g., Interceed]. If Interceed is the only one, please make agents singular and say something like “An oxidizing regenerating cellulose agent (Interceeds, …..) has been described. (line 106
   Response Thank you for this clarification. Yes, only one I wish to comment on in the manuscript (intercede). Will remove the plural form

9 Which one? (line 110)
   Response – Surgicel. Added to text

10 Rather than give the brand name of this suture, please give the generic and whether it is absorbable or not (line 137)
   Response – thank you for this clarification. I deleted the brand name and provided a generic description

11 Not sure what you mean by “where” which references a place. Perhaps “was able to undergo endovaginal ultrasound for evaluation of postmenopausal bleeding, during which a polyp was noted.” (line 161)
   Response –Yes, perfect. Thank you for this grammatical correction and recommendation. I changed the text accordingly
marked in the track changes in the attached manuscript. When revising, please leave the track changes on, and do not use the “Accept all Changes” function in Microsoft Word. Please respond to the comments in the track changes and address each of the queries below in a point-by-point response. For your reference, I have copied the author queries below:

1. The journal avoids using brand names everywhere but in the body text. Okay to use “Oxidizing Regenerating Cellulose Agent” as the generic term? This has been replaced throughout. (line 4)
2. “Hemostatic Agent” okay here? (line 50)
3. None of your teaching points has anything to do w/ recurrent agglutination or use of surgical. As this is the topic of your paper, at least one of them should, preferably the first one. (line 83)
4. Any references regarding the rates of recurrence? (line 105)
5. This is plural but you’ve named one. If its an example of several, please indicate that in the parentheses [like e.g., Interceed]. If Interceed is the only one, please make agents singular and say something like “An oxidizing regenerating cellulose agent (Interceeds, ..... ) has been described. (line 106)
6. Which one? (line 110)
7. Rather than give the brand name of this suture, please give the generic and whether it is absorbable or not (line 137)
8. Not sure what you mean by “where” which references a place. Perhaps “was able to undergo endovaginal ultrasound for evaluation of postmenopausal bleeding, during which a polyp was noted.” (line 161)

In order to keep your manuscript moving through our process, please respond within 48 hours.

Regards,

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