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

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

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

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

Questions about these materials may be directed to the Obstetrics & Gynecology editorial office: obgyn@greenjournal.org.
RE: Manuscript Number ONG-19-1364

Preemptive oral versus intravenous acetaminophen for postoperative pain in minimally invasive gynecologic surgery: A Triple-Blind Randomized Trial

Dear Dr. Lombardi:

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 Sep 09, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: This is well written clear manuscript for a RCT comparing oral versus intravenous acetaminophen for post-operative pain. This is very timely clinical trial as ERAS is increasingly being adopted nation-wide.

The research question: is meaningful and clinically valid, with a potential to change clinical practice.

The manuscript title: Despite that the study only included patients scheduled for robotic assisted laparoscopic hysterectomy for benign indications, the title of the manuscript does not reflect that; I recommend to change the title to reflect what is actually being studied.

Precis: should also be edited to reflect that only robotic cases were included. (lines 19-20)

Abstract: Same comment to be applied in Objective (line 22) and Methods (line 24).

Introduction (line 63): There are multiple retrospective studies that focused on the same question, stating that "there are no studies in gynecologic surgery, however, comparing the effectiveness of oral acetaminophen with IV acetaminophen." is not correct. Please acknowledge the following studies:


M&M: well written with proper methodology used.

Results and Discussion: well written, properly supported by data.

Reviewer #2: This is a randomized controlled trial comparing oral and IV acetaminophen before robotic assisted laparoscopic hysterectomy.
1. Title: Please be specific regarding the procedure type in the title (robotic assisted laparoscopic hysterectomy—is this the same as a robotic hysterectomy?).

2. Abstract methods: be specific regarding type of procedure and also add the time before the surgery that the meds were administered


4. Methods: Given the results of the above paper, was there any thought to adding a 3rd placebo arm to the study?

5. Methods: What are the other routine medications administered preop for ERAS at this institution? The regimen should be reported.

6. Methods: What pain medications were administered by anesthesia intraop? Was it standardized?

7. Intro/Discussion: Please do a more thorough literature search for previous studies addressing IV acetaminophen and hysterectomy-examples on quick search below:

Preemptive Oral Acetaminophen for Women Undergoing Total Laparoscopic Hysterectomy.
Atkins JR, Titch JF, Norcross WP, Thompson JA, Muckler VC.

Administration of Oral Acetaminophen to Reduce Costs for the Hysterectomy Patient at a Community Hospital.
Blonk KM, Davenport A, Morgan B, Muckler VC.

Improved Outcomes Associated With the Use of Intravenous Acetaminophen for Management of Acute Post-Surgical Pain in Cesarean Sections and Hysterectomies.

Reviewer #3: This manuscript adds to a growing body of literature on ERAS pathways. The study represents an appropriately rigorous protocol for the evaluation of non-inferiority of oral versus IV acetaminophen prior to minimally invasive hysterectomy. The primary and secondary endpoints were clear, and the study was appropriately powered and designed to evaluate for the intended outcomes. I have several comments/suggestions to the authors:

1) Since you did not measure plasma concentrations of acetaminophen, I don't think you can reasonable conclude that "higher plasma concentrations don't necessarily correlate with clinical effectiveness from a pain control standpoint" (line 166).

2) You mention that the pain scores were in the "mild" range by VAS. Is it possible that the mild nature of the pain resulted in minimal effect of the interventions? Your study was designed to detect non-inferiority, and not efficacy, but I wonder if it's possible to determine non-inferiority of a pain intervention when pain is minimal at baseline. This might be something to include in your discussion. The sources that you cite for supporting use of acetaminophen in ERAS pathways were open procedures, or non-gynecologic procedures. To your knowledge, has the efficacy of preoperative acetaminophen been evaluated in minimally invasive procedures? If not, your study may, in actuality, have demonstrated non-inferiority of two non-effective interventions for pain. As stated, your study results may not be generalizable to non-minimally invasive gynecologic procedures.

3) Your study design and blinding are certainly a strength of your study, but you don't need to restate the individual components of the protocol, or to explain the blinding in the discussion (line 191).

STATISTICAL EDITOR COMMENTS:
The Statistical Editor makes the following points that need to be addressed:
Table 1: Since this was a RCT, there is no need to statistically compare baseline characteristics of the two cohorts, since any difference is thought to be due to random chance. If there were thought (during design phase) to be important baseline characteristics worthy of a balanced design, then that should have been factored into the randomization (ie, by
block) phase. The cohorts have \( n = 37 \) and \( 38 \), so there is no basis for citing \%s \( \text{to nearest 0.1\%} \), should round to nearest integer \%.

Table 2 and lines 32-33 and 97-100: The sample size calculation is based on one primary outcome, using a one-sided alpha= 0.025, that is the pain assessment at 2 hours post-op. Therefore, the other time points evaluated (4 and 24 hrs) are not primary, which would have required a stricter alpha and therefore a greater sample size. Also, since the primary was formatted in terms of non-inferiority, that should be how the results of comparison at 2 hours should be formatted (difference in score with 95\% CI) and conclusion stated using the nomenclature of non-inferiority testing. Table 2 makes no distinction among the outcomes and states the comparisons in the usual format of hypothesis testing. Need to clearly separate in Table and text the one primary outcome, and state it in non-inferiority language. The other outcomes are all secondary, were not included in the power analysis and therefore any NS findings cannot be generalized, only reported.

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 Randi Zung and she will send it by email - rzung@greenjournal.org.***

- please note that the indications for hysterectomy may be benign, but the surgery itself is not benign or malignant. please reword here and throughout.

- We no longer require that authors adhere to the Green Journal format with the first submission of their papers. However, any revisions must do so. I strongly encourage you to read the instructions for authors (the general bits as well as those specific to the feature-type you are submitting). The instructions provide guidance regarding formatting, word and reference limits, authorship issues, and other things. Adherence to these requirements with your revision will avoid delays during the revision process, as well as avoid re-revisions on your part in order to comply with the formatting.

- Can you state that "the study supports the use of preoperative oral acetaminophen....

- Its not the idea of preemptive analgesia that has improved post op pain, its actual preemptive analgesia that does this, correct?

- In line 52, please eliminate either "largely" or "primarily" as they are redundant with each other.

- perhaps "less expensive" rather than "cheaper" for the journal?

- Please order your methods chronologically. For instance, here you are telling us right off about how the drug/placebo were given. but then down in 119 you again talk about giving the drugs. It flows better if you present all of this chronologically (randomization first, etc.)

- please state clearly here that you chose NOT to analyze by intention to treat. This is very unusual and needs to be articulated.

- please first report that primary outcome endpoint and then mention that the others were also no different. Primary outcome always mentioned first.

- by default or is this just surgeon preference?

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. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:

A. OPT-IN: Yes, please publish my point-by-point response letter.

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

3. 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.

Please check with your coauthors to confirm that the disclosures listed in their eCTA forms are correctly disclosed on the manuscript’s title page.

4. Use of "triple blind": Please change this to "double-blind" for all instances. The 3rd group blinded, I’m assuming, are the assessors of the outcomes and good RCT methodology would ALWAYS have them blinded.

5. Clinical trials submitted to the journal as of July 1, 2018, must include a data sharing statement. The statement should indicate 1) whether individual deidentified participant data (including data dictionaries) will be shared; 2) what data in particular will be shared; 3) whether additional, related documents will be available (eg, study protocol, statistical analysis plan, etc.); 4) when the data will become available and for how long; and 5) by what access criteria data will be shared (including with whom, for what types of analyses, and by what mechanism). Responses to the five bullet points should be provided in a box at the end of the article (after the References section).

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 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.

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. Abstracts for all randomized, controlled trials should be structured according to the journal’s standard format. The Methods section should include the primary outcome and sample size justification. The Results section should begin with the dates of enrollment to the study, a description of demographics, and the primary outcome analysis. Please review the sample abstract that is located online here: http://edmgr.ovid.com/ong/accounts/sampleabstract_RCT.pdf. Please edit your abstract as needed.

11. 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.

12. 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.

13. In your Abstract, manuscript Results sections, and tables, the preferred citation should be in terms of an effect size, such as odds ratio or relative risk or the mean difference of a variable between two groups, expressed with appropriate confidence intervals. When such syntax is used, the P value has only secondary importance and often can be omitted or noted as footnotes in a Table format. Putting the results in the form of an effect size makes the result of the statistical test more clinically relevant and gives better context than citing P values alone.
If appropriate, please include number needed to treat for benefits (NNTb) or harm (NNTh). When comparing two procedures, please express the outcome of the comparison in U.S. dollar amounts.

Please standardize the presentation of your data throughout the manuscript submission. For P values, do not exceed three decimal places (for example, “P = .001”). For percentages, do not exceed one decimal place (for example, 11.1%”).

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

15. Figure 1 should be resubmitted with the revision as-is.

16. 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.

17. If you choose to revise your manuscript, please submit your revision through Editorial Manager at http://ong.editorialmanager.com. Your manuscript should be uploaded in a word processing format such as Microsoft Word. Your revision’s cover letter should include the following:

* A confirmation that you have read the Instructions for Authors (http://edmgr.ovid.com/ong/accounts/authors.pdf), and
* A point-by-point response to each of the received comments in this letter.

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 Sep 09, 2019, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

Nancy C. Chescheir, MD
Editor-in-Chief

2018 IMPACT FACTOR: 4.965
2018 IMPACT FACTOR RANKING: 7th out of 83 ob/gyn journals

In compliance with data protection regulations, you may request that we remove your personal registration details at any time. (Use the following URL: https://www.editorialmanager.com/ong/login.asp?a=r). Please contact the publication office if you have any questions.
September 8, 2019

To whom it may concern,

I wish to submit an original research article entitled “Preemptive oral versus intravenous acetaminophen for postoperative pain after robotic-assisted laparoscopic hysterectomy: A Double-Blind Randomized Trial” for consideration by Obstetrics & Gynecology. I confirm that this work is original and has not been published elsewhere, nor is it currently under consideration for publication elsewhere.

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 have been explained.

This study has been registered on ClinicalTrials.gov with reference number NCT03391284. This study was approved by the local IRB at Scripps Memorial Hospital La Jolla in San Diego, California. There was a delay in posting this trial to ClinicalTrials.gov. At our institution, there is no administrative support person in charge of posting qualifying clinical trials to the website. At the time the study was approved, it was not clearly communicated to myself nor my co-investigators that this specific responsibility lie with the sponsor of the trial. We did not become aware of this until late December 2017 which is why the trial was posted in early January 2018. This abstract was accepted and presented as a poster at the AAGL 2018 Global Congress.

In this paper, we show that oral acetaminophen is not inferior to intravenous acetaminophen when given before robotic-assisted laparoscopic hysterectomy performed for benign indications. This is significant because it adds to the growing body of literature supporting oral medications as part of enhanced recovery after surgery (ERAS) pathways. ERAS pathways are showing increasing value in maintaining patient satisfaction and improving outcomes, while minimizing length of stay and lowering hospital costs. I believe this manuscript is appropriate for publication by Obstetrics & Gynecology because randomized trials assessing specific aspects of ERAS pathways in regards to minimally invasive gynecologic surgery performed for benign indications are limited. By adding to this body of literature, quality studies such as this can help advance and promote evidenced-based women’s healthcare.

Neither myself nor any of my co-authors have no conflicts of interest to disclose.

The authors acknowledge the Instructions for Authors data sheet has been reviewed. After initial review, please find reviewer comments and my subsequent response to each as follows:
Reviewer #1:

- “Despite that the study only included patients scheduled for robotic assisted laparoscopic hysterectomy for benign indications, the title of the manuscript does not reflect that; I recommend to change the title to reflect what is actually being studied.” The manuscript title, precis, and abstract have been revised to indicate that robotic-assisted laparoscopic hysterectomy was specifically assessed in this study.
- “There are multiple retrospective studies that focused on the same question, stating that "there are no studies in gynecologic surgery, however, comparing the effectiveness of oral acetaminophen with IV acetaminophen" is not correct.” At the time of initial literature review at this study’s conception in 2015/2016 the original statement made by the authors was correct, however the authors do acknowledge these newer publications in regards to this study question. These references have been added to the manuscript and the original statement has been corrected as seen in lines 65-69.

Reviewer #2:

- “Please be specific regarding the procedure type in the title (robotic assisted laparoscopic hysterectomy--is this the same as a robotic hysterectomy?).” The manuscript title, precis, and abstract have been revised to indicate that robotic-assisted laparoscopic hysterectomy was specifically assessed in this study.
- “Be specific regarding type of procedure and also add the time before the surgery that the meds were administered” Due to word limits in the abstract, the time before surgery the medications were administered could not be included. It was felt all other included information was more important to include in the abbreviated abstract. Times are clearly stated, however, in the manuscript body under the Methods section.
- “I don't see this recent paper discussed: Turner LC, Zyczynski HM, Shepherd JP Intravenous Acetaminophen Before Pelvic Organ Prolapse Repair: A Randomized Controlled Trial. Obstet Gynecol. 2019 Mar;133(3):492-502.” After review of this reference it was felt not applicable to be included in this manuscript as it was dealing with pelvic organ prolapse surgery specifically. Comparing this type of surgery to robotic-assisted laparoscopic hysterectomy is not felt to be relevant.
- “Given the results of the above paper, was there any thought to adding a 3rd placebo arm to the study?” At the time of this study’s design in 2015/2016, obviously the information elucidated in the referenced paper published in 2019 was not available for review to impact our study design. An addition was made in the manuscript, however, indicating that adding a third group who received all placebo medications could have further strengthened this study’s results, as seen in lines 209-212.
- “What are the other routine medications administered preop for ERAS at this institution? The regimen should be reported.” At the time this study was completed, our institution did not have a formal ERAS protocol for gynecologic surgery, so no additional preoperative medications were administered. This was indicated in lines 115-116.
- “What pain medications were administered by anesthesia intraop? Was it standardized?” This was not specifically analyzed in this study and has been commented on in lines 205-207.
- “Please do a more thorough literature search for previous studies addressing IV acetaminophen and hysterectomy” At the time of initial literature review at this study’s
conception in 2015/2016 the original statement made by the authors was correct, however the authors do acknowledge the newer publications in regards to this study question. These references have been added to the manuscript and the original statement has been corrected as seen in lines 65-69.

Reviewer #3:

- “Since you did not measure plasma concentrations of acetaminophen, I don't think you can reasonable conclude that "higher plasma concentrations don't necessarily correlate with clinical effectiveness from a pain control standpoint" (line 166).” *The original statement has been revised to reflect the sentiments in this reviewer’s comment which are reasonable, as seen in lines 161-164.*
- “You mention that the pain scores were in the "mild" range by VAS. Is it possible that the mild nature of the pain resulted in minimal effect of the interventions? Your study was designed to detect non-inferiority, and not efficacy, but I wonder if it's possible to determine non-inferiority of a pain intervention when pain is minimal at baseline. This might be something to include in your discussion. The sources that you cite for supporting use of acetaminophen in ERAS pathways were open procedures, or non-gynecologic procedures. To your knowledge, has the efficacy of preoperative acetaminophen been evaluated in minimally invasive procedures? If not, your study may, in actuality, have demonstrated non-inferiority of two non-effective interventions for pain. As stated, your study results may not be generalizable to non-minimally invasive gynecologic procedures.” *The authors do acknowledge these opinions and have commented on them in lines 209-212.*
- “Your study design and blinding are certainly a strength of your study, but you don't need to restate the individual components of the protocol, or to explain the blinding in the discussion (line 191).” *This description has been removed from the discussion.*

Statistical Editor:

- “Table 1: Since this was a RCT, there is no need to statistically compare baseline characteristics of the two cohorts, since any difference is thought to be due to random chance. If there were thought (during design phase) to be important baseline characteristics worthy of a balanced design, then that should have been factored into the randomization (ie, by block) phase. The cohorts have n = 37 and 38, so there is no basis for citing %s to nearest 0.1%, should round to nearest integer %.” *I can acknowledge and appreciate that if randomization was performed correctly, comparison of baseline characteristics should not be important as stated, any differences would be due to chance. However I do still feel it is important to verify and report that the randomization was done correctly, and that both groups being compared were in fact equal across these various parameters. All tables have been corrected to round percentages to the nearest integer.*
- “Table 2 and lines 32-33 and 97-100: The sample size calculation is based on one primary outcome, using a one-sided alpha= 0.025, that is the pain assessment at 2 hours post-op. Therefore, the other time points evaluated (4 and 24 hrs) are not primary, which would have required a stricter alpha and therefore a greater sample size. Also, since the primary was formatted in terms of non-inferiority, that should be how the results of comparison at 2 hours should be formatted (difference in score with 95% CI) and
conclusion stated using the nomenclature of non-inferiority testing. Table 2 makes no distinction among the outcomes and states the comparisons in the usual format of hypothesis testing. Need to clearly separate in Table and text the one primary outcome, and state it in non-inferiority language. The other outcomes are all secondary, were not included in the power analysis and therefore any NS findings cannot be generalized, only reported.” The distinction to separate the primary outcome in table and text is also acknowledged and appreciated. In the Methods section you’ll see this reflected in lines 118-119, in Results lines 137-138, in Discussion lines 153-154, and in the final conclusion with lines 214-216. Table 2 has been updated to more clearly highlight the primary outcome. The differences between groups is already being highlighted in this table to reflect non-inferiority.

Editor:

- “Please note that the indications for hysterectomy may be benign, but the surgery itself is not benign or malignant. please reword here and throughout.” This statement has been reworded throughout the paper to reflect “hysterectomy performed for benign indications”.
- “Can you state that "the study supports the use of preoperative oral acetaminophen...." This statement has been revised in lines 43-45 to reflect this study supports the use of oral over IV acetaminophen.
- “Its not the idea of preemptive analgesia that has improved post op pain, its actual preemptive analgesia that does this, correct?” This statement has been updated as seen in line 49-52.
- “In line 52, please eliminate either "largely" or "primarily" as they are redundant with each other.” The sentence in lines 52-54 has been edited.
- “Perhaps "less expensive" rather than "cheaper" for the journal?” “Cheaper” has been replaced with “less expensive” throughout the manuscript.
- “Please order your methods chronologically. For instance, here you are telling us right off about how the drug/placebo were given. but then down in 119 you again talk about giving the drugs. It flows better if you present all of this chronologically (randomization first, etc.)” The Methods section has been updated per these recommendations to follow chronological order.
- “Please state clearly here that you chose NOT to analyze by intention to treat. This is very unusual and needs to be articulated.” The decision to analyze by per protocol was not necessarily intentional. The study participants who were excluded (one who underwent orogastric tube placement at the start of the surgery, and the second who was taken back to the OR on postoperative day 1 for acute bleeding) did not have all outcomes measured as the study protocol wasn’t followed in their cases. Since all outcomes were not measured for adequate comparison, they were not included for final analysis. In hindsight, this was not intentional so as to analyze by per protocol over intention to treat. In retrospect as you point out, they should have had all outcomes assessed as possible so as to analyze by intention to treat.
- “Please first report that primary outcome endpoint and then mention that the others were also no different. Primary outcome always mentioned first.” Throughout the manuscript the primary outcome has been stated separately and the 2 other endpoints for pain assessment were cleared stated as secondary outcomes.
• “By default or is this just surgeon preference?” This statement has been edited as seen in lines 178-180.

• “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. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:
  A.    OPT-IN: Yes, please publish my point-by-point response letter.
  B.    OPT-OUT: No, please do not publish my point-by-point response letter.”
  The authors opt-in for this option.

• “Use of "triple blind": Please change this to "double-blind" for all instances. The 3rd group blinded, I'm assuming, are the assessors of the outcomes and good RCT methodology would ALWAYS have them blinded.” While the authors do feel this study meets criteria to be titled a triple-blind study, the change to double-blind has been reflected throughout the manuscript.

• “Clinical trials submitted to the journal as of July 1, 2018, must include a data sharing statement. The statement should indicate 1) whether individual deidentified participant data (including data dictionaries) will be shared; 2) what data in particular will be shared; 3) whether additional, related documents will be available (eg, study protocol, statistical analysis plan, etc.); 4) when the data will become available and for how long; and 5) by what access criteria data will be shared (including with whom, for what types of analyses, and by what mechanism). Responses to the five bullet points should be provided in a box at the end of the article (after the References section).” This section has been added following References as indicated.

• “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 athttps://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.” The authors feel comfortable with ACOG reVITALize definitions.

• “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.” Abstract updated to include advised requirements. Abstract word count 297.

The authors do appreciate the constructive feedback to improve this manuscript. With these revision, we hope the manuscript will be accepted for publication. We once again thank you for your consideration of this manuscript.
Sincerely,
Tresa Lombardi, MD