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-20-1691

Safety and Feasibility of Discharge without an Opioid Prescription for Patients Undergoing Gynecologic Surgery

Dear Dr. Pothuri:

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).

***Due to the COVID-19 pandemic, your paper will be maintained in active status for 30 days from the date of this letter. If we have not heard from you by Aug 16, 2020, we will assume you wish to withdraw the manuscript from further consideration.***

REVIEWER COMMENTS:

Reviewer #1: 1. p.2, line 35 and p.6, line 91. The authors mention "...institutional support...", but there is no mention in the text of specific "institutional support" needed to implement this quality improvement intervention. Briefly describe the institutional investment in time and other resources to implement this intervention.
2. p.3, line 58, p.12, lines 221 and 225, etc. Numbers of patients as well as percentages should be provided throughout the text.
3. p.4, line 60. The authors state that 532 patients had surgery, but it appears that only 170 had a post-operative visit. This should be clarified.
4. p.5, line 79. Suggest 'intensity' instead of "severity".
5. p.9, line 153. To whom were patients counseled to call? Was it a central number so study protocol could be followed and statistics gathered?
6. p.11, line 205. The authors should provide an exact number and percentage instead of stating "...approximately 40% of cases...".
7. p.12, line 237. Of the patients whose pain was not adequately controlled, how many (%) had an opioid prescription refill?
8. p.13, lines 246-248. Very briefly describe the time commitment to teach involved physicians, advanced practitioners, and nursing staff about the quality improvement initiative, and how this was integrated into routine practice.
9. p.13, line 261. What, exactly, was "...more radical..."?
10. p.14, lines 268-271. How do the authors know that "...this is the first report..."? Did they do a literature search? If so, it should be described.
11. p.16, lines 322-324. This sentence is subjective, and may be deleted without altering the intent or quality of the paper.
12. Table 3. Briefly explain why pre-operative counseling was documented in only 85.9% of cases.

Reviewer #2: This is a historical comparison of before and after a quality improvement project implementation regarding opioid prescriptions upon discharge after gynecologic surgery at one institution on the gynecologic oncology service. The study incorporates many different types of surgeries from diagnostic laparoscopy to laparotomy with debulk.
1. Abstract Methods: Would specify that abdominal incisions means laparoscopy, robotic, laparotomy etc.
2. Introduction: Please make more clear how your study differs from Mark et al. and Glaser et al. Also, in the Discussion.
3. Methods: Please cite evidence that postoperative gabapentin makes a difference in gynecologic surgery pain management at home. Why was this included?
4. Methods: For MIS patients discharged on POD 1, what was the postop opioid dosing in the hospital after the PACU? e.g. was it every 4 hours, every 6 hours, what counted as more than 5 opioid administrations and was there enough time to
even reach 5? Similarly, what was the standard opioid dosing in the hospital postoperatively for laparotomy patients?

5. Methods: Besides phone calls, were ED visits postoperatively tracked? Would the patients have gone to a different hospital?

Reviewer #3: 1. No discussion/conclusion was provided for the abstract in my submission materials.

2. A 2 week washout period was used. This is probably adequate, but the authors may wish to examine their results it the first month of analysis. If compliance was poor at that time, the results presented may be underestimated.

3. It is not clear if the calculation of average pills prescribed included the zero pills for those not given a prescription, or just included patients issued a prescription. This appears to different for MIS vs. laparotomy. Please clarify in the manuscript.

4. Use of gabapentin: I offer the following information not as a criticism of the study, but for your awareness and consideration, and I think some discussion is needed to inform the readership as well. Although over a dozen publications on this topic by one anesthesiologist were retracted for being falsified data, gabapentin has indeed been shown to reduces opioid use in other investigations. However, the reduction is only about 1 pill/day. Other studies have confirmed that is causes drowsiness, much like your findings, and in fact there is a significant increase in RRT calls in the PACU and use of naloxone. While these events are rare, they are serious, and for that reason we and many other institutions have discontinued our use of gabapentin preop. It should not be used at all in elderly patients, and I would suggest you reconsider its use both pre and certainly postoperatively. I highly doubt discontinuation will impact your success in reducing opioid use.

STATISTICAL EDITOR COMMENTS:

The Statistical Editor makes the following points that need to be addressed:

Lines 59-60, 230-240: Since this proportion only reflects responses from 170 of 256 (66%), it is an insufficient sample to generalize re: satisfaction with pain control and there is no comparison with the pre-intervention group to measure how satisfaction compared with a cohort for which opioid Rx were more liberally given. Also, the counts for the various subsets of surgery are likely too few to allow sufficient power to generalize the NS finding of no difference in satisfaction by type of surgery.

Table 1: Need units for BMI. The number of prior surgeries can only have integer values. Should either summarize as median(IQR) or as categories, not as mean(SD).

Table 2: Length of surgery and length of stay are often non-normally distributed. If so for these data, then should omit the mean(SD) comparisons. Similarly for last pain score, was it normally distributed? If not, then should omit the mean(SD). The first and second opioid refills should be based on the number which had an initial Rx for opioid. The %s appear to be based on the entire cohorts of N = 276 and N = 256. If some of these were not refills, but new Rx for opioids, then that should be clarified. If the counts given were based on those who had an initial opioid Rx, then the %s should be (based on abstract’s %s of 82.7% and 23.1%), then the 1st refill rates are 18/228 (7.9%) vs 15/59 (25%), which has Chi-square = 13.2, p < 0.001 and for the 2nd refill: 5/18 vs 3/15 has p = 0.70 by Fisher’s test. In other words, post intervention, the opioid Rx were given on a more restrictive basis and a higher percentage of that cohort requested a refill.

Table 3: For the rows: laparotomy, ambulatory, MIS and ambulatory/MIS hysterectomy, should give the denominators, since those were subsets of the N = 256.

Fig 2: Either within these figures or in supplemental material, should include the actual counts in each group and provide a summary of relevant statistical comparisons between pre and post and across surgical types.

EDITOR 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. 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.

2. For studies that report on the topic of race, authors must provide an explanation in the manuscript of who classified individuals’ race, ethnicity, or both, the classifications used, and whether the options were defined by the investigator or the participant. In addition, the reasons that race/ethnicity were assessed in the study also should be described (eg, in the
Methods section and/or in table footnotes).

Use "Black" and "White" (capitalized) when used to refer to racial categories.

The category of "Other" is a grouping/label that should be avoided, unless it was a prespecified formal category in a database or research instrument. If you use "Other" in your study, please add detail to the manuscript to describe which patients were included in that category.

3. Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting randomized controlled trials (ie, CONSORT), observational studies (ie, STROBE), observational studies using ICD-10 data (ie, RECORD), meta-analyses and systematic reviews of randomized controlled trials (ie, PRISMA), harms in systematic reviews (ie, PRISMA for harms), studies of diagnostic accuracy (ie, STARD), meta-analyses and systematic reviews of observational studies (ie, MOOSE), economic evaluations of health interventions (ie, CHEERS), quality improvement in health care studies (ie, SQUIRE 2.0), and studies reporting results of Internet e-surveys (CHERRIES). Include the appropriate checklist for your manuscript type upon submission. Please write or insert the page numbers where each item appears in the margin of the checklist. Further information and links to the checklists are available at http://ong.editorialmanager.com. In your cover letter, be sure to indicate that you have followed the CONSORT, MOOSE, PRISMA, PRISMA for harms, STARD, STROBE, RECORD, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

4. 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 data definitions at https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-obstetrics-data-definitions and the gynecology data definitions at https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-gynecology-data-definitions. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

5. 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.

6. 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).

7. 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 limit for Original Research articles is 300 words; Reviews is 300 words; Case Reports is 125 words; Current Commentary articles is 250 words; Executive Summaries, Consensus Statements, and Guidelines are 250 words; Clinical Practice and Quality is 300 words; Procedures and Instruments is 200 words. Please provide a word count.

8. Please use only the standard headings for an Original Research paper and remove any subheadings: in the Abstract: Objective, Methods, Results, Conclusion; and in the body text: Introduction, Methods, Results, Discussion.

9. Please revise "and/or" to mean either "and" or "or." Be sure this is done throughout your paper.

10. 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%).

11. Your manuscript contains a priority claim. ("To date, this is the first report of a drastic reduction in opioid prescribing..."
for patients undergoing laparotomy or minimally invasive hysterectomy, enabling discharge without an opioid prescription altogether in over 75% of patients.

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

12. 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.

13. When you submit your revision, art saved in a digital format should accompany it. Please upload each figure as a separate file to Editorial Manager (do not embed the figure in your manuscript file).

Figures 1-2: Please upload as separate figure files on Editorial Manager.

14. Each supplemental file in your manuscript should be named an "Appendix," numbered, and ordered in the way they are first cited in the text. Do not order and number supplemental tables, figures, and text separately. References cited in appendixes should be added to a separate References list in the appendixes file.

15. 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 https://wkauthorservices.editage.com/open-access/hybrid.html.

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 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 30 days from the date of this letter. If we have not heard from you by Aug 16, 2020, we will assume you wish to withdraw the manuscript from further consideration.***

Sincerely,

The Editors of Obstetrics & Gynecology

2019 IMPACT FACTOR: 5.524
2019 IMPACT FACTOR RANKING: 6th out of 82 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.
August 1st, 2020

Dear Editorial Board,

Please find attached a revised copy of the manuscript of original research titled, “Safety and Feasibility of Discharge without an Opioid Prescription for Patients Undergoing Gynecologic Surgery” for consideration for publication in Obstetrics and Gynecology. We greatly appreciate the thoughtful and constructive commentary provided by the three reviewers, statistical editor and editor and have given them extensive consideration. We have revised the manuscript to a state we feel confident is worthy of publication. Below please find a detailed description of our responses to each comment with references to page and line numbers as seen on the “simple markup” version of track changes.

I affirm that this manuscript is an honest, accurate, and transparent account of the original study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained. This manuscript is not under review or published anywhere else. All listed authors have contributed substantially to the research detailed in this manuscript and meet the conditions for claiming authorship. Additionally, all authors have seen and approve of this submission. All other clinicians and supporting staff listed under the acknowledgements section have provided written consent to be listed in the manuscript. This study was approved by the NYU Langone Health institutional review board.

Preliminary data from this project was presented as a poster at the 2020 Society of Gynecologic Oncology meeting (Virtual due to COVID-19, initially planned for Toronto).

Sincerely,

Bhavana Pothuri, MD
Reviewer #1:

1. p.2, line 35 and p.6, line 91. The authors mention "...institutional support...", but there is no mention in the text of specific "institutional support" needed to implement this quality improvement intervention. Briefly describe the institutional investment in time and other resources to implement this intervention.
   a. We agree that the words institutional support were vague. The last sentence of the introduction (page 6 lines 91-93) has been changed to avoid vague language in the body of the text. The mention in the methods (page 7 lines 113-114) of enhancing pre-operative counseling sessions with additional information and discussion points is one of the areas of institutional support. Changes in our pre-existing ERP protocol was another area of institutional support that is described in lines (page 7, lines 124-128). We have also included a statement on the general time to train staff for these interventions on page 9 lines 169-171.

2. p.3, line 58, p.12, lines 221 and 225, etc. Numbers of patients as well as percentages should be provided throughout the text.
   a. This has been added throughout the text

3. p.4, line 60. The authors state that 532 patients had surgery, but it appears that only 170 had a post-operative visit. This should be clarified.
   a. Thank-you for this comment. This has been clarified in the main body of the text. The percentage of post-operative patients who had completed post-operative survey data was 170. All patients had a post-operative visit. Given the points raised by the statistical editor at the smaller percentage of the entire intervention group that had data for this question, we decided to remove this from the abstract as it is not a main finding of the study.

4. p.5, line 79. Suggest 'intensity' instead of "severity".
   a. Change made in the text, page 5 now line 82

5. p.9, line 153. To whom were patients counseled to call? Was it a central number so study protocol could be followed and statistics gathered?
   a. Clarification provided in the text on page 9 lines 159-162. Patient phone calls at our institution are routinely documented and there was no study team to track patient calls outside of the normal workflow.

6. p.11, line 205. The authors should provide an exact number and percentage instead of stating "...approximately 40% of cases...".

7. p.12, line 237. Of the patients whose pain was not adequately controlled, how many (%) had an opioid prescription refill?
   a. Additional data provided in text to address comment and clarify that this population of patients were those who had post-operative surveys completed. Even though this is essentially a convenience sampling, we still felt it was important to accurately portray it as such and include this data. Page 13 lines 254-258.

8. p.13, lines 246-248. Very briefly describe the time commitment to teach involved physicians, advanced practitioners, and nursing staff about the quality improvement initiative, and how this was integrated into routine practice.
   a. Details have been added in the methods section on page 9 lines 169-172 in response to previous comment

9. p.13, line 261. What, exactly, was "...more radical..."?
   a. Thank-you for this comment. We agree with comment, this statement was vague and has been removed. We would like to make the point that even in the published literature for which there are several studies with opioid prescription reductions, most of them still sent the majority of patients with an opioid prescription and our study stands out in that we discharged the majority of patients without an opioid prescription. (page 14 lines 281-284)

10. p.14, lines 268-271. How do the authors know that "...this is the first report..."? Did they do a literature search? If so, it should be described.
a. Removed this statement and replaced with details that highlight the unique aspects of our intervention (Pages 14-15, lines 290-293)

11. p.16, lines 322-324. This sentence is subjective, and may be deleted without altering the intent or quality of the paper.
   We agree with the above statement, however we feel that the spirit of this intervention is to empower surgeons that their prescribing decisions make a difference. We feel that making this point helps solidify the intentions of this quality improvement initiative. Just as important as “proving” that patients can safely be discharged without opioids, we stress that providers should value this approach.

12. Table 3. Briefly explain why pre-operative counseling was documented in only 85.9% of cases.
   a. These data reflect real world practices for a quality improvement intervention that was undertaken without a dedicated and separately paid research team and is addressed in the discussion on page 15 lines 305-307.
   Reasons for lack of documentation of preoperative counseling could include the lack of a documented nursing teaching note in a small minority of cases or a nursing teaching note in which the proper documentation was not completed. Clarification added in lines 302-303.

Reviewer #2: This is a historical comparison of before and after a quality improvement project implementation regarding opioid prescriptions upon discharge after gynecologic surgery at one institution on the gynecologic oncology service. The study incorporates many different types of surgeries from diagnostic laparoscopy to laparotomy with debulk.

1. Abstract Methods: Would specify that abdominal incisions means laparoscopy, robotic, laparotomy etc.
   a. The term “minimally invasive and open abdominal surgery” is now used in the abstract (page 3 lines 43-44).

2. Introduction: Please make more clear how your study differs from Mark et al. and Glaser et al. Also, in the Discussion.
   a. Thank you for this comment. We highlight our focus on page 6 lines 91-92 that our focus was on specific reporting of ambulatory MIS hysterectomy and laparotomy without opioid. Details provided in the discussion on page 14 lines 290-293 which set our study apart from those that are previously published.

3. Methods: Please cite evidence that postoperative gabapentin makes a difference in gynecologic surgery pain management at home. Why was this included?
   a. Evidence cited in the methods section on page 7 lines 128-129

4. Methods: For MIS patients discharged on POD 1, what was the postop opioid dosing in the hospital after the PACU? e.g. was it every 4 hours, every 6 hours, what counted as more than 5 opioid administrations and was there enough time to even reach 5? Similarly, what was the standard opioid dosing in the hospital postoperatively for laparotomy patients?
   a. This has been clarified on page 8 lines 148-152. By choosing 5 doses as our threshold we essentially were trying to capture people who received all PRN doses of opioid pain medications and then required breakthrough pain medication as a proxy for people who stayed in the hospital for poor pain control. We wanted to avoid sending a patient with an opioid prescription who stayed overnight for nausea, or a case that finished late if they used only a few opioid doses during their hospital stay.

5. Methods: Besides phone calls, were ED visits postoperatively tracked? Would the patients have gone to a different hospital?
   a. Thank-you for this comment. This was included as a limitation on page 17, lines 343-347. It is rare that a patient seeks peri operative care at an outside institution without any documentation in our medical record that this has happened. We also have access to EPIC care-everywhere to capture this.
Reviewer #3:

1. No discussion/conclusion was provided for the abstract in my submission materials.
   a. This has been added and was an error, page 4 lines 59-63

2. A 2 week washout period was used. This is probably adequate, but the authors may wish to examine their results in the first month of analysis. If compliance was poor at that time, the results presented may be underestimated.
   a. Compliance for the first month was added to Table 3 (page 21). The biggest intervention that took time to gear up was documentation of preoperative counseling. Anecdotally, this was likely due to a slow uptake of the use of a new EPIC smart phrase to document the pre-operative counseling. The rest of the data support a fast uptake of the intervention with an expected slower uptake of discharging laparotomy patients without opioid prescriptions.

3. It is not clear if the calculation of average pills prescribed included the zero pills for those not given a prescription, or just included patients issued a prescription. This appears to different for MIS vs. laparotomy. Please clarify in the manuscript.
   a. Clarification provided in the legend for figure 2, due to the lower compliance of the prescribing for laparotomy patients, some were sent home with higher numbers of opioid prescriptions which accounts for their averages being higher. Their averages do include those prescribed no opioids and calculations were consistent across groups. Prior to the intervention, many patients were sent home with prescriptions of 12-20 pills which contributes to the average of 9.8. In the 6 month post intervention period only 15 patients were sent with prescriptions of more than 12 pills, 9 of which were in the laparotomy group. We chose to include those without opioid prescriptions as the intention of the paper was to reduce the overall prescribing burden among all patients in the practice, and this would not have been captured if averages only included those who were prescribed opioids.

4. Use of gabapentin: I offer the following information not as a criticism of the study, but for your awareness and consideration, and I think some discussion is needed to inform the readership as well. Although over a dozen publications on this topic by one anesthesiologist were retracted for being falsified data, gabapentin has indeed been shown to reduces opioid use in other investigations. However, the reduction is only about 1 pill/day. Other studies have confirmed that is causes drowsiness, much like your findings, and in fact there is a significant increase in RRT calls in the PACU and use of naloxone. While these events are rare, they are serious, and for that reason we and many other institutions have discontinued our use of gabapentin preop. It should not be used at all in elderly patients, and I would suggest you reconsider its use both pre and certainly postoperatively. I highly doubt discontinuation will impact your success in reducing opioid use.
   a. Thank you for this comment. We included on page 15 lines 295-296 mention of the consideration of risk/benefit profile for this component of the intervention given its side effects. The timing of our intervention in accordance with new resident influx could also explain the prolonged anesthesia times and somnolence in few patients as this is a commonly experienced phenomenon in the beginning of the year. We did not comment on in the manuscript as this is an anecdotal statement.

STATISTICAL EDITOR COMMENTS:

The Statistical Editor makes the following points that need to be addressed:
1. Lines 59-60, 230-240: Since this proportion only reflects responses from 170 of 256 (66%), it is an insufficient sample to generalize re: satisfaction with pain control and there is no comparison with the pre-intervention group to measure how satisfaction compared with a cohort for which opioid Rx were more liberally given. Also, the counts for the various subsets of surgery are likely too few to allow sufficient power to generalize the NS finding of no difference in satisfaction by type of surgery.
   a. We agree that this sampling of patients is limited and is not generalizable. We have included this as a limitation of our study in the discussion section on page 16 lines 321-324. We do however still think it is worth recognizing that among those we surveyed the vast majority did not report issues with postoperative pain control.

2. Table 1: Need units for BMI. The number of prior surgeries can only have integer values. Should either summarize as median (IQR) or as categories, not as mean (SD)
   a. These changes have been made in the text

3. Table 2: Length of surgery and length of stay are often non-normally distributed. If so for these data, then should omit the mean (SD) comparisons. Similarly for last pain score, was it normally distributed? If not, then should omit the mean (SD). The first and second opioid refills should be based on the number which had an initial Rx for opioid. The %s appear to be based on the entire cohorts of N = 276 and N = 256. If some of these were not refills, but new Rx for opioids, then that should be clarified. If the counts given were based only on those who had an initial opioid Rx, then the %s should be (based on abstract’s %s of 82.7% and 23.1%), then the 1st refill rates are 18/228 (7.9%) vs 15/59 (25%), which has Chi-square = 13.2, p < 0.001 and for the 2nd refill: 5/18 vs 3/15 has p = 0.70 by Fisher’s test. In other words, post intervention, the opioid Rx were given on a more restrictive basis and a higher percentage of that cohort requested a refill
   a. Thank-you for this comment. Length of surgery, Length of stay and number of opioid doses in 24 hours prior to discharge were not normally distributed and means have been removed. Last pain score at time of discharge was normally distributed and this has been included in the legend for table 2 (Page 19 line 375)
   b. We have clarified in the text that the main outcome of the paper was post discharge opioid prescriptions inclusive of refills and new prescriptions (page 9 lines 163, 175). You correctly point out that the word refill implies that a prescription was given initially. The main goal of the intervention was to limit prescriptions without burdening patients to travel to a pharmacy more frequently to obtain a prescription post operatively. It was also to use the need for a new postoperative opioid prescription after discharge as a proxy for patients who were suffering from poor pain control. Therefore we were less interested in whether or not the patient was initially prescribed an opioid in accordance with our prescribing algorithm for this data point, but rather wanted to capture if patients needed to pick up a prescription outside of usual prescribing practices.

4. Table 3: For the rows: laparotomy, ambulatory, MIS and ambulatory/MIS hysterectomy, should give the denominators, since those were subsets of the N = 256
   a. This was corrected in the manuscript

5. Fig 2: Either within these figures or in supplemental material, should include the actual counts in each group and provide a summary of relevant statistical comparisons between pre and post and across surgical types.
   a. Additional data requested provided as Appendix 2 (page 26), referenced page 12 line 237

EDITOR 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. If you opt out of including your response, only the
A. AGREE TO 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.

2. For studies that report on the topic of race, authors must provide an explanation in the manuscript of who classified individuals’ race, ethnicity, or both, the classifications used, and whether the options were defined by the investigator or the participant. In addition, the reasons that race/ethnicity were assessed in the study also should be described (eg, in the Methods section and/or in table footnotes). Use "Black" and "White" (capitalized) when used to refer to racial categories. Change made in the table 1, page 29

The category of "Other" is a grouping/label that should be avoided, unless it was a prespecified formal category in a database or research instrument. If you use "Other" in your study, please add detail to the manuscript to describe which patients were included in that category.

Response: Page 10 lines 181-185 provides detail on how race was classified. For many patients race was classified in our electronic medical record as “other” per the patient’s self-identification.

3. Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting randomized controlled trials (ie, CONSORT), observational studies (ie, STROBE), observational studies using ICD-10 data (ie, RECORD), meta-analyses and systematic reviews of randomized controlled trials (ie, PRISMA), harms in systematic reviews (ie, PRISMA for harms), studies of diagnostic accuracy (ie, STARD), meta-analyses and systematic reviews of observational studies (ie, MOOSE), economic evaluations of health interventions (ie, CHEERS), quality improvement in health care studies (ie, SQUIRE 2.0), and studies reporting results of Internet e-surveys (CHERRIES). Include the appropriate checklist for your manuscript type upon submission. Please write or insert the page numbers where each item appears in the margin of the checklist. Further information and links to the checklists are available at

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Response: SQUIRE 2.0 was reviewed

4. 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 data definitions at

https://urldefense.proofpoint.com/v2?url=https-3A__www.acog.org_practice-2Dmanagement_health-2Dit-2Dand-2Dclinical-2Dinformatics_revitalize-2Dobstetrics-2Ddata-2Ddefinitions&d=DwIGaQ&c=j5oPpO0eBH1iio48DtseedEIZfc04rx3ExJHeliIZuCs&rs=RwtVktPlSpxmUHVeElb-9ZaNHE3EAgnT1Wr091ves&m=gbBNS37LfaVUAtobaOsRPsj82L4W5y147ICFc_WtYg&s=Tba8zRIOtfBxz7QUHQB_KbNS64xEYSIfZOLpRc&e= and the gynecology data definitions at

https://urldefense.proofpoint.com/v2?url=https-3A__www.acog.org_practice-2Dmanagement_health-2Dit-2Dand-2Dclinical-2Dinformatics_revitalize-2Dgynecology-2Ddata-2Ddefinitions&d=DwIGaQ&c=j5oPpO0eBH1iio48DtseedEIZfc04rx3ExJHeliIZuCs&rs=RwtVktPlSpxmUHVeElb-9ZaNHE3EAgnT1Wr091ves&m=gbBNS37LfaVUAtobaOsRPsj82L4W5y147ICFc_WtYg&s=ltrOF3rS5mJ2NU6YWh2PDPj84xSYFRpjmxg_mpEkA&e=. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

Response: None of the definitions outlined in the reVITALize Obstetric Data Definitions (Version 1.0 ) are included in this manuscript

5. 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.

26 pages total, 23 pages of text with 3 pages of references, additional page pushing us over limit was to include appendix 2 data

Word count: total document 5741 minus 597 for references = 5,144

6. 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).

Response: All acknowledgements and disclosures have been made

7. 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.

Response: The abstract has been checked for consistency with the manuscript body

In addition, the abstract length should follow journal guidelines. The word limit for Original Research articles is 300 words; Reviews is 300 words; Case Reports is 125 words; Current Commentary articles is 250 words; Executive Summaries, Consensus Statements, and Guidelines are 250 words; Clinical Practice and Quality is 300 words; Procedures and Instruments is 200 words. Please provide a word count.

Response: Abstract word count 287

8. Please use only the standard headings for an Original Research paper and remove any subheadings: in the Abstract: Objective, Methods, Results, Conclusion; and in the body text: Introduction, Methods, Results, Discussion.

Response: This has been corrected

9. Please revise “and/or” to mean either “and” or “or.” Be sure this is done throughout your paper.

Response: This has been corrected

10. 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%”).

Response: We are adherent to this guideline

11. Your manuscript contains a priority claim. (“To date, this is the first report of a drastic reduction in opioid prescribing for patients undergoing laparotomy or minimally invasive hysterectomy, enabling discharge without an opioid prescription altogether in over 75% of patients.”) We discourage claims of first reports since they are often difficult to prove. How do you know this is the first report? If this is based on a systematic search of the literature, that search should be described in the text (search engine, search terms, date range of search, and languages encompassed by the search). If it is not based on a systematic search but only on your level of
awareness, it is not a claim we permit.

Response: This has been deleted.

12. Please review the journal’s Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: https://urldefense.proofpoint.com/v2/url?u=http-3A__edmgr.ovid.com_ong_accounts_table-5Fchecklist.pdf&d=DwIGaQ&c=j5oPpO0eBH1io48DtSedeElZfc04rx3ExJHeliIZuCs&r=RwtVktPldSPxmUHVefElb-9ZaNHE3EAgmT1Wr091wes&m=gbBNS37LFaViURAobaOsRPsj82L4W5y47iCFc_WtYg&s=fNd59N95YCdM_WkLV_c3G5A6i4aT
TAH_28sbdmnTMKuY&e=. Response: Tables conform to guidelines

13. When you submit your revision, art saved in a digital format should accompany it. Please upload each figure as a separate file to Editorial Manager (do not embed the figure in your manuscript file). Figures 1-2: Please upload as separate figure files on Editorial Manager.

Response: Figures have been uploaded separately

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Response: We are adherent to this guideline

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* A point-by-point response to each of the received comments in this letter.
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