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

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

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-20-2970

Sociodemographic Disparities in NCCN Guideline Adherent Treatment for Endometrial Cancer

Dear Dr. Rodriguez:

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 Feb 19, 2021, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1:

1. Did you classify Hawaiians of Asian ethnicity as Asians or as Pacific Islanders?
2. Lines 121-123 Did you exclude patients not treated surgically?
3. Lines 176-180 Better treatment at higher stages, probably those were referred to gyn oncology.
4. Lines 186-189 Was the worse outcome related to later diagnosis and worse histology?
5. Lines 241-248 The group treated less well were less likely to be unstaged. How do you explain the paradox?
6. What about the better results when referred to gyn oncology, did you look at that?

Reviewer #2:

This is a retrospective cohort study from the SEER database investigating SES status and racial/ethnic disparities in NCCN guideline compliance in women with endometrial cancer.

Strengths:
* This is an extremely large and reliable data set, so there is relatively little risk of loss of accuracy. There is reliable data on the first course of treatment in this database.
* This is the only study I am aware of that explores compliance with NCCN guidelines in general, or broken down by racial-ethnic categories or SES, so this has novel information, most importantly that compliance with NCCN guidelines is low in general and even lower amongst disadvantaged populations.
Limitations:
* Socioeconomic status is a big beast, and many factors play into SES, including income, debt, insurance status, and geographical location of living. The title and abstract indicate that the authors are referring to this as one item ("socioeconomic status"), and don't give the reader an idea of what markers are being used in the data. From reading the manuscript, we know that neighborhood is the single factor used, but that is not clear in the title and abstract. Using only Yost quintiles is a bit of a gross oversimplification of SES in general.
* Race and ethnicity are reported together, as opposed to separately, which is not really the recommended way of sorting these categories. "Latina" is not a race, and people can be from a variety of racial backgrounds and still identify ethnicity as Hispanic or non-Hispanic.
* As the authors go to the effort of discovering what compliance rates were with NCCN guidelines, I would love to see slightly more granularity to the data in where in treatment guidelines were not being followed. Are less Black women getting radiation, or more getting improper chemotherapy? More granularity would be more informative about where exactly treatment is breaking down. The authors postulate a lot about where women of lower SES or non-White race are being deprived in the treatment paradigm in the conclusions, but their data is not granular enough to support that they are not getting specific parts of treatment.
* The Methods could use a bit more clarity and specificity, as simply designating things like "covariates" does not specifically tell the reader what was corrected for in the regression analyses.

Comments for authors by section:

Title:
* The title is not completely accurate, as most of the results and methods discuss discovering the racial and ethnic differences in following of guidelines, but racial and ethnic disparities in nowhere in the title. That is really the most interesting result of this study, that regardless of SES, non-White race is a risk for non-compliance with guidelines.

Abstract:
* Line 58: It should be stated briefly here that the only marker of SES used was neighborhood SES.
* Line 59-60: I would suggest removing this first sentence of the Abstract and using the resulting space for giving more statistics after the association of SES with following of guidelines and describing that the neighborhood SES was used.

Introduction:
* Line 107: Please include a hypothesis.

Methods:
* Line 126-127: This is perhaps just my non-familiarity with the data set, but how was this variable determined. Was compliance with NCCN determined by the SEER database already, or did the authors comb the data to determine this for each individual patient? This should be very clearly laid out, as this is the sole dependent variable.
* Line 136-140: Is this the only way these could be classified based on the data available? As race and ethnicity are considered to separate axes (see my comment above), if they could be analyzed as two separate independent axes, that would have been better. If that was not possible based on the dataset, please clarify that here.
* Line 140-141: Was there an "other" or category of people who do not identify with one race or one ethnicity? If people did not identify, I assume they were excluded.
* Line 145-146: Using this as the only marker of SES is a bit overly simplistic.
* Line 163: What, specifically, were the clinical covariates used?
* Line 165: A post-hoc power analysis would be merited here, to describe how much power this large dataset has to detect differences between quintiles in SES or between different racioethnic groups.

Results:
* Line 203: Again, the Methods should have better laid out what demographic and clinical covariates were used, and how these were determined.
* Line 211-212: Does this include controlling for race/ethnicity as well? In other words, make it very clear to the reader if SES by neighborhood is still a factor in compliance controlling for race and other covariates, AND THAT RACE/ETHNICITY is still a factor controlling for neighborhood SES and other covariates.

Discussion:
* The first paragraph of this section should review what sort of study this was and the main findings, not summarize the state of the literature (yet).
* Line 257-258: I agree that this is interesting and demands future study. Aggregates of race make it very difficult to determine where bias cuts.
* Line 274-276: This is an interesting finding, but from this analysis we have no idea what parts of treatment are being denied or not accessible to women of SES. Do they not have access to hysterectomy? Not have access to radiation? At what state/histological types are women suffering the most from their SES or racial status?
* Line 319: Going beyond "Black and White" is not that notable; ideally, this paper would comply with the racial and ethnic guidelines as laid out by the NIH.
Reviewer #3:

The authors have utilized the SEER data base to evaluate compliance of management according to the NCCN guidelines. With such a data base numerous items can be identified and differences noted as it is quite large; however, other items of interest are not available.

1. For instance does NCCN guidelines in this cancer affect prognosis?
2. Although grade was evaluated was the data the same for Type 1 and 2 cancers?
3. Differences in treatment compliance is highly significant but the actual differences was only 4-5% (race evaluation). Is this really clinically significant?
4. Although both race and SES were independently significant in regards to treatment compliance were combinations evaluated ie Blacks are in a lower SES, could those in that category account for the poor compliance?
5. Is the higher SES in Asians the reason for better treatment compliance?

The manuscript is well written and would publish after above addressed.

STATISTICS EDITOR COMMENTS:

Table 1: Should clarify for the reader that (1) the Table refers to %s and (2) only the first row and the last column refer to %s that were adherent, the remaining entries refer to %s within a particular stratum and (3) whether these %s are based on the crude counts, or weighted to be more representative. Also, as supplemental, should show the actual counts within each entry. The study period is from 2006-2015. Why was the year of study not included in the analysis, since in Table 3 there was a weak, albeit statistically significant association of year vs adherence? What evidence is presented that the adherence rates or patient profiles (SES, Age, Stage etc.) remained invariant from 2006-2015, thus allowing aggregation regardless of year of study?

Table 3: Need to include concise statement in footnote explaining the covariates included in each Model. The columns of p-values are redundant, since CIs are included with ORs. Should designate as aORs or adjusted ORs when applicable.

EDITORIAL OFFICE COMMENTS:

1. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter. 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. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA). 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
3. For studies that report on the topic of race or include it as a variable, 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). Race/ethnicity must have been collected in a formal or validated way. If it was not, it should be omitted. Authors must enumerate all missing data regarding race and ethnicity as in some cases, missing data may comprise a high enough proportion that it compromises statistical precision and bias of analyses by race.

Use "Black" and "White" (capitalized) when used to refer to racial categories. The nonspecific category of "Other" is a convenience 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.

4. If applicable: In order for an administrative database study to be considered for publication in Obstetrics & Gynecology, the database used must be shown to be reliable and validated. In your response, please tell us who entered the data and how the accuracy of the database was validated. This same information should be included in the Materials and Methods section of the manuscript.

5. Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting observational studies (ie, STROBE), observational studies using ICD-10 data (ie, RECORD), studies of diagnostic accuracy (ie, STARD). 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.

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 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.

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 limit for Original Research articles is 300 words. Please provide a word count.

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

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. ACOG is moving toward discontinuing the use of "provider." Please replace "provider" throughout your paper with either a specific term that defines the group to which are referring (for example, "physicians," "nurses," etc.), or use "health care professional" if a specific term is not applicable.

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. Your manuscript contains a priority claim. 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.

15. 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.
16. Please review examples of our current reference style at http://ong.editorialmanager.com (click on the Home button in the Menu bar and then "Reference Formatting Instructions" document under "Files and Resources"). Include the digital object identifier (DOI) with any journal article references and an accessed date with website references. Unpublished data, in-press items, personal communications, letters to the editor, theses, package inserts, submissions, meeting presentations, and abstracts may be included in the text but not in the reference list.

In addition, the American College of Obstetricians and Gynecologists' (ACOG) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite ACOG documents in your manuscript, be sure the reference you are citing is still current and available. If the reference you are citing has been updated (ie, replaced by a newer version), please ensure that the new version supports whatever statement you are making in your manuscript and then update your reference list accordingly (exceptions could include manuscripts that address items of historical interest). If the reference you are citing has been withdrawn with no clear replacement, please contact the editorial office for assistance (obgyn@greenjournal.org). In most cases, if an ACOG document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All ACOG documents (eg, Committee Opinions and Practice Bulletins) may be found at the Clinical Guidance page at https://www.acog.org/clinical (click on "Clinical Guidance" at the top).

17. Figure 1: Please consider adding an exclusion box between the first two boxes.

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

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).

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

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

Art that is low resolution, digitized, adapted from slides, or downloaded from the Internet may not reproduce.

18. 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.

19. 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.

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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. Do not omit your responses to the Editorial Office or Editors' comments.
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 Feb 19, 2021, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

John O. Schorge, MD
Associate Editor, 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.
February 18, 2021

To Dr. John O. Schorge, Associate Editor:

Please find attached a revised manuscript entitled “Sociodemographic Disparities in NCCN Guideline Adherent Treatment for Endometrial Cancer” [ONG-20-2970] that we are re-submitting as an original research article solely to Obstetrics & Gynecology. Based on reviewer feedback we have updated the title of our manuscript to “Racial-Ethnic and Socioeconomic Disparities in Guideline Adherent Treatment for Endometrial Cancer”. Our study has followed STROBE guidelines, as appropriate. Each co-author has contributed substantially to the paper and approved the version being submitted. All individuals named in the acknowledgements section gave written permission to be named. Neither my co-authors nor I have conflicts of interest to disclose. As the corresponding author and first-author, I conceived of this paper and had personal full access to all aspects of the research and writing process. I take final responsibility for the paper.

The reviewers’ comments, queries, and suggestions were very insightful and valuable to improving this manuscript to be acceptable for publication in Obstetrics & Gynecology. On the following pages, we respond to each of the reviewers’ comments in a point-by-point fashion. We have separated our response to you from our response to the reviewer to maintain the anonymity of the peer review process.

Please do not hesitate to contact me with any questions. If the manuscript is ultimately accepted for publication, we elect to OPT IN (Yes, please publish our point-by-point response letter). We hope that the enclosed changes will be acceptable for a resubmission of this manuscript. Thank you in advance for your time and consideration of our revised manuscript.

With best regards,

Victoria E. Rodriguez, MSW, MPH
University of California, Irvine
Department of Health, Society, and Behavior
RE: Manuscript ID ONG-20-2970 “Racial-Ethnic and Socioeconomic Disparities in Guideline Adherent Treatment for Endometrial Cancer”

Reviewer #1 Comments:

1. Did you classify Hawaiians of Asian ethnicity as Asians or as Pacific Islanders?
   We thank Reviewer #1 for this query. We realize we did not describe accurately where Hawaiians fit into the racial/ethnic categories analyzed. Hawaiians were included in the same category with Pacific Islanders. We have revised the manuscript to make this clear and have changed the category of Pacific Islanders throughout the manuscript text to read “Native Hawaiian or Pacific Islander (NHPI)”.

2. Lines 121_123. Did you exclude patients not treated surgically?
   We thank Reviewer #1 for this query. We excluded patients that had unknown surgical treatment (n=48) as detailed in Figure 1. We did not exclude patients that were not surgically treated as this would inaccurately represent treatment adherence specifically within surgical treatment recommendations. To make this exclusion criteria clearer, we have edited our manuscript on page 7 lines 120-124. Specifically, we write “A total of 83,883 cases of endometrial carcinomas were included as the final study population (see Figure 1) after excluding cases with unknown race-ethnicity, unknown stage of diagnosis, unknown census track information, missing or unknown clinical data (surgical treatment, extent of disease, diagnostic confirmation, and surgical staging), and cases or information obtained from autopsy or death certificates.”

3. Lines 176_180. Better treatment at higher stages, probably those were referred to gyn oncology.
   Reviewer #1 raises a great question. While physician specialty may be an important provider characteristic to observe in relation to treatment adherence for endometrial cancer, the SEER database does not collect treating physician characteristics in order to see differences in treatment adherence between gynecologic oncologists and other types of physicians. We hope to examine this in future studies but for this study we have acknowledged this as a limitation on page 16 lines 335-337. Specifically, we write: “For instance, the SEER registry does not have granular information related to access to care and hospital or physician characteristics (i.e., insurance coverage and type, geographic location, facility type, physician specialty).” Additionally, we have included this as a recommendation for future research to look at patterns in treatment adherence based on physician specialty among other hospital or physician characteristics on page 15 lines 311-314. Specifically, we write: “Future research should explore what factors may mitigate or exacerbate these disparities such as insurance status, geographical location, access and barriers to treatment, physician specialty, physician bias, hospital volume, and hospital type (e.g., academic versus community).”

4. Lines 186_189. Was the worse outcome related to later diagnosis and worse histology?
   We thank Reviewer #1 for their query. In our multivariate analysis we found that compared to Stage I disease, women with Stage IV disease had significantly lower odds of receiving adherent treatment (OR=0.31, 95%CI: 0.29-0.33). We also found in our multivariate analysis that women with non-endometroid carcinomas were significantly less likely to get adherent treatment (OR=0.56, 95%CI: 0.54-0.58) compared with women with endometroid carcinomas. From our data we also observed that Black women represented a higher proportion of later stage at diagnosis and worse histology and in our multivariate analysis they were significantly less likely to have adherent treatment (OR=0.89, 95%CI: 0.84-0.94) compared to white women. While we were able to see these associations between stage of disease, histology, and Black race this data and these analyses do not provide adequate information to make causal inferences on whether later diagnosis and worse histology was the driver of rates of adherent treatment within this population of endometrial carcinoma cancer cases.
5. Lines 241-248. The group treated less well were less likely to be unstaged. How do you explain the paradox? We thank Reviewer #1 for their query. We recognize that our original sentence written in the manuscript was confusing and did not accurately represent the findings of the cited literature. We have revised this sentence for accuracy and clarity. Specifically, on pages 12-13 lines 251-256, we write: “Further, one study found that American Indian or Alaska Native women with endometrial cancer had surgical staging that was aligned with national guidelines. Given that American Indian or Alaska Native women experienced the lowest prevalence of treatment adherence in our study and were significantly less likely to receive adherent treatment compared to White women, further research is needed to examine treatment adherence with larger sample sizes of American Indian or Alaska Native women.”

6. What about the better results when referred to gyn oncology, did you look at that? Reviewer #1 raises a great question. While physician specialty may be an important provider characteristic to observe in relation to treatment adherence for endometrial cancer, the SEER database does not collect treating physician characteristics in order to assess differences in treatment adherence between gynecologic oncologists and other types of physicians. We hope to examine this in future studies but for this study we have acknowledged this as a limitation on page 16 lines 335-337. Specifically, we write: “For instance, the SEER registry does not have granular information related to access to care and hospital or physician characteristics (i.e., insurance coverage and type, geographic location, facility type, physician specialty).” Additionally, we have included this as a recommendation for future research to look at patterns in treatment adherence based on physician specialty among other hospital or physician characteristics on page 15 lines 311-314. Specifically, we write: “Future research should explore what factors may mitigate or exacerbate these disparities such as insurance status, geographical location, access and barriers to treatment, physician specialty, physician bias, hospital volume, and hospital type (e.g., academic versus community).”

Reviewer #2 Comments: This is a retrospective cohort study from the SEER database investigating SES status and racial/ethnic disparities in NCCN guideline compliance in women with endometrial cancer.

Strengths:
* This is an extremely large and reliable data set, so there is relatively little risk of loss of accuracy. There is reliable data on the first course of treatment in this database.
* This is the only study I am aware of that explores compliance with NCCN guidelines in general, or broken down by racial-ethnic categories or SES, so this has novel information, most importantly that compliance with NCCN guidelines is low in general and even lower amongst disadvantaged populations.

Limitations:
* Socioeconomic status is a big beast, and many factors play into SES, including income, debt, insurance status, and geographical location of living. The title and abstract indicate that the authors are referring to this as one item ("socioeconomic status"), and don't give the reader an idea of what markers are being used in the data. From reading the manuscript, we know that neighborhood is the single factor used, but that is not clear in the title and abstract. Using only Yost quintiles is a bit of a gross oversimplification of SES in general.
* Race and ethnicity are reported together, as opposed to separately, which is not really the recommended way of sorting these categories. "Latina" is not a race, and people can be from a variety of racial backgrounds and still identify ethnicity as Hispanic or non-Hispanic.
* As the authors go to the effort of discovering what compliance rates were with NCCN guidelines, I would love to see slightly more granularity to the data in where in treatment guidelines were not being followed. Are less Black women getting radiation, or more getting improper chemotherapy? More granularity would be more informative about where exactly treatment is breaking down. The authors
postulate a lot about where women of lower SES or non-White race are being deprived in the treatment paradigm in the conclusions, but their data is not granular enough to support that they are not getting specific parts of treatment.

* The Methods could use a bit more clarity and specificity, as simply designating things like "covariates" does not specifically tell the reader what was corrected for in the regression analyses.

Comments for authors by section:

Title:

7. The title is not completely accurate, as most of the results and methods discuss discovering the racial and ethnic differences in following of guidelines, but racial and ethnic disparities in nowhere in the title. That is really the most interesting result of this study, that regardless of SES, non-White race is a risk for non-compliance with guidelines.
   We appreciate the comments of Reviewer #2 and agree that our title does not accurately describe the focus and findings of our study. We have revised our title to read “Racial-Ethnic and Socioeconomic Disparities in Guideline Adherent Treatment for Endometrial Cancer”.

Abstract:

8. Line 58: It should be stated briefly here that the only marker of SES used was neighborhood SES.
   We thank Reviewer #2 for this commentary. We have revised page 3 line 57 to read “neighborhood socioeconomic status” as opposed to the previous “socioeconomic status” in order to clearly note that the only marker of SES used was neighborhood SES. We also have revised this phrase throughout our manuscript to emphasize that our study is looking at neighborhood SES versus individual-level SES.

9. Line 59-60: I would suggest removing this first sentence of the Abstract and using the resulting space for giving more statistics after the association of SES with following of guidelines and describing that the neighborhood SES was used.
   We thank Reviewer #2 for this comment and recommendation. We have included specifics regarding the findings of neighborhood SES in our abstract on page 3 lines 62-66. Specifically, we write: “After controlling for covariates, there was a gradient by neighborhood SES: Women in the high-middle (OR=0.89, p < 0.001), middle (OR=0.84, p < 0.001), low-middle (OR=0.80, p < 0.001) and lowest (OR=0.73, p < 0.001) neighborhood SES categories had lower odds of receiving adherent treatment than the highest neighborhood SES group.” Additionally, in order to stay in line with the word count for the abstract we have edited out other portions of our abstract as recommended from this reviewer.

Introduction:

10. Line 107: Please include a hypothesis.
    We thank Reviewer #2 for their request. We have included our hypothesis for this study page 6 lines 107-109. Specifically, we write, “We hypothesized that racial-ethnic minorities and women of lower neighborhood socioeconomic status would have lower percentages of adherence to NCCN treatment guidelines.”

Methods:

11. Line 126-127: This is perhaps just my non-familiarity with the data set, but how was this variable determined. Was compliance with NCCN determined by the SEER database already, or did the authors comb the data to determine this for each individual patient? This should be very clearly laid out, as this is the sole dependent variable.
    We thank Reviewer #2 for their comments and insightful thoughts. To more clearly describe that this was a variable we constructed using the SEER data, we have updated our methods section on page 7 lines 125-131 to read: “The primary dependent variable was adherence to NCCN guidelines for the first course of treatment, accounting for guideline changes that occurred during the study time period. NCCN guidelines recommended a combination of therapies dependent on histological subtype (e.g., endometroid carcinomas or other carcinomas) and extent of disease (e.g., diseases limited to uterus,
suspected or gross cervical involvement, and suspected extrauterine disease). Based on the NCCN guidelines, we combined the corresponding data to create a binary variable representing adherence to NCCN guidelines (1=adherent treatment, 0=non-adherent treatment).

12. Line 136-140: Is this the only way these could be classified based on the data available? As race and ethnicity are considered to separate axes (see my comment above), if they could be analyzed as two separate independent axes, that would have been better. If that was not possible based on the dataset, please clarify that here.

We thank Reviewer #2 for this commentary and query. We respectfully disagree however that race and ethnicity should be analyzed as two separate independent axes. We recognize that government classification of race and ethnicity, particularly in the Census breaks race and ethnicity into two separate questions: 1) Are you of Hispanic, Latino, or Spanish origin? and 2) What is your race? However, in epidemiologic research race and ethnicity are rarely distinguished from one another, nor are these treated as two separate identities in practice. Further, research on racism and the health of Latinos in the United States shows that Latinos experience racism and are racialized as their own racial group even though they are considered to be an ethnic group in the United States. Within that framework, we utilized the variable “race_ethnic” in the SEER dataset that has the response categories of Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian/Alaska Native, Non-Hispanic Asian or Pacific Islander, Hispanic (All Races), and Unknown. Additionally, in order to disaggregate Non-Hispanic Asian or Pacific Islander we used the variable “race” which details the race of respondents (i.e., Chinese, Filipino, Hmong, etc) and “race_ethnic” to create a new variable of race/ethnicity with the response categories: Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian/Alaska Native, Non-Hispanic Asian, Non-Hispanic Native Hawaiian or Pacific Islander, Hispanic (All Races), and Unknown. As detailed in Figure 1, we excluded only respondents with an “unknown” race/ethnicity. Moreover, our analysis utilizing the aforementioned racial and ethnic group categories is aligned with recently published articles in Obstetrics and Gynecology that focus on racial and ethnic disparities.


13. Line 140-141: Was there an "other" or category of people who do not identify with one race or one ethnicity? If people did not identify, I assume they were excluded.

We thank Reviewer #2 for this query. The response categories in the SEER dataset for the variable “race_ethnic” are as follows: Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian/Alaska Native, Non-Hispanic Asian or Pacific Islander, Hispanic (All Races), and Unknown. There were no response categories of “Other” or “Multiple Races”. As detailed in Figure 1, we excluded only respondents with an “unknown” race/ethnicity.
14. **Line 145-146**: Using this as the only marker of SES is a bit overly simplistic. We wholeheartedly agree with Reviewer #2 on this point. We recognize that using neighborhood SES is a limitation and does not fully account for the various factors that represent SES. Unfortunately, the SEER dataset does not have information on individual-level SES for participants. Therefore, we used the only available variable of SES in this dataset, neighborhood SES, as a proxy of community-level SES which has been shown in past research to be consistently associated with various health outcomes.\textsuperscript{1-6} Nonetheless, we have acknowledged this in our limitations on page 17 lines 359-362. Specifically, we write: “Lastly, we did not have access to individual level socioeconomic status, so we used neighborhood socioeconomic status as a proxy for community-level socioeconomic status, which may not account fully for the role of individual level socioeconomic status on these associations.”


15. **Line 163**: What, specifically, were the clinical covariates used? We thank Reviewer #2 for their comments and query. Reviewer #2 raises a question that we believe we have adequately described in the methods section of the original manuscript. Specifically, it reads on page 8 lines 151-158: “Clinical characteristics included stage of diagnosis, histology, grade of disease, histological subtype, and year of diagnosis. Stage of diagnosis was a categorical variable with four categories ranging from stage I (reference group) to stage IV. Histology was coded as a binary variable with the categories including endometroid carcinomas and other carcinomas. Grade was categorized into five groups: grade 1 well differentiated (reference group), grade 2 moderately differentiated, grade 3 poorly differentiated, grade 4 undifferentiated or anaplastic, and unknown. Year of diagnosis was treated as a continuous variable.” However, we recognize that our original sentence presenting the overarching themes of the covariates included in our study was not clear. In order to address the Reviewer’s question, the following edit has been added to our methods section on page 8 line 148 to read: “Covariates included demographic and clinical characteristics.”

16. **Line 165**: A post-hoc power analysis would be merited here, to describe how much power this large dataset has to detect differences between quintiles in SES or between different racioethnic groups. We thank Reviewer #2 for this suggestion. We have conducted a post-hoc power analysis and found that this dataset is powered for Black and Latina women and underpowered for Asian, Native Hawaiian or Pacific Islander, and American Indian or Alaska Native women indicating the need for larger sample sizes of these groups in future research. Additionally, we found that we were powered for all SES groups. We have added this information to our manuscript on page 10 lines 204-209, specifically we write: “Post-hoc power analysis determined that this study was not adequately powered to detect significant racial-ethnic differences in treatment for Asian, Native Hawaiian or Pacific Islander, and
American Indian or Alaska Native women relative to White women when conducting two-tailed analyses at $\alpha=0.05$ and 80% power indicating the importance of future studies that include larger sample sizes of these groups. This study was adequately powered at $\alpha=0.05$ and 80% power to detect differences in all neighborhood SES groups.

Results:

17. Line 203: Again, the Methods should have better laid out what demographic and clinical covariates were used, and how these were determined.

We thank Reviewer #2 for this comment. We have revised our methods section to better explain our independent variables and covariates used in this study. Specifically, on pages 7-8 lines 134-158 we write: “The main independent variables were race-ethnicity of the patient and neighborhood socioeconomic status (SES). Race-ethnicity was classified into six groups: non-Latina White (reference group), non-Latina Black, Latina, non-Latina Asian, non-Latina Native Hawaiian or Pacific Islander, and non-Latina American Indian or Alaska Native (henceforth White, Black, Latina, Asian, Native Hawaiian or Pacific Islander, and American Indian or Alaska Native). There were no multi-racial groups reported in the SEER dataset. Racial-ethnic variables for the SEER dataset are ascertained through medical records or administrative information as opposed to patient’s self-reported racial-ethnic identity. Neighborhood SES was classified into quintiles based on the Yost score ranging from highest neighborhood SES (reference group) to lowest neighborhood SES32. The Yost score is a composite index of neighborhood SES using census tracts and several indicators of education, income, and occupation.32 Education was represented by an education index, occupation included proportion with a blue-collar job and proportion older than 16 years of age in the workforce without a job, and income included median household income, proportion below 200% of the poverty level, median rent, and median house value.32 Covariates included demographic and clinical characteristics. Demographic characteristics included age at diagnosis. Age at diagnosis was used as a categorical variable with four groups based on quartile distribution, younger than 54 years (reference group), 54 to 61 years, 62 to 68 years, and 69 years and older. Clinical characteristics included stage of diagnosis, histology, grade of disease, histological subtype, and year of diagnosis. Stage of diagnosis was a categorical variable with four categories ranging from stage I (reference group) to stage IV. Histology was coded as a binary variable with the categories including endometroid carcinomas and other carcinomas. Grade was categorized into five groups: grade 1 well differentiated (reference group), grade 2 moderately differentiated, grade 3 poorly differentiated, grade 4 undifferentiated or anaplastic, and unknown. Year of diagnosis was treated as a continuous variable.”

18. Line 211-212: Does this include controlling for race/ethnicity as well? In other words, make it very clear to the reader if SES by neighborhood is still a factor in compliance controlling for race and other covariates, AND THAT RACE/ETHNICITY is still a factor controlling for neighborhood SES and other covariates.

We appreciate the comments and queries of Reviewer #2. We have revised the text to make clear that neighborhood SES is still associated with treatment adherence after controlling for race/ethnicity and all covariates. Specifically, on page 11 lines 220-225 we write: “We continue to see the gradient pattern for neighborhood socioeconomic status after controlling for race-ethnicity and all covariates relative to women in the highest neighborhood SES group: High-middle neighborhood SES group (OR=0.89, p < 0.001, 95% CI 0.86-0.93), middle neighborhood SES group (OR=0.84, p < 0.001, 95% CI 0.80-0.88), low-middle neighborhood SES group OR=0.80, p < 0.001, 95% CI 0.78-0.86) and lowest neighborhood SES group (OR=0.73, p < 0.001, 95% CI 0.69-0.77).”

Discussion:

19. The first paragraph of this section should review what sort of study this was and the main findings, not summarize the state of the literature (yet).

We thank Reviewer #2 for this comment. We have edited the beginning of our discussion to reflect the recommendations of Reviewer #2. Specifically, pages 11-12 lines 227-237 we write: “This study was a retrospective population-based cohort study using the SEER database which aimed to evaluate the
association of race-ethnicity and neighborhood socioeconomic status with adherence to NCCN guidelines for endometrial cancer and to examine disparities. Our findings suggest racial-ethnic and neighborhood socioeconomic disparities in receipt of adherent care, which aligns with past studies on endometrial cancer and other cancer sites. There are limited studies that have examined adherence to NCCN guidelines for endometrial cancer and even fewer that have looked at racial-ethnic and neighborhood socioeconomic disparities in treatment adherence\textsuperscript{21–23}. As adherence to NCCN guidelines are associated with improved survival for many cancer sites, including uterine cancer, it is important to explore disparities and deviations in these guidelines among various racial-ethnic and neighborhood socioeconomic status groups to ensure that all groups are receiving equitable treatment."

20. Line 257-258: I agree that this is interesting and demands future study. Aggregates of race make it very difficult to determine where bias cuts.
   We thank Reviewer #2 for their kind comments. We agree with Reviewer #2’s statement that disaggregated data is needed in future studies especially between Asians and Native Hawaiian or Pacific Islanders with the inclusion of larger sample sizes to make meaningful conclusions.

21. Line 274-276: This is an interesting finding, but from this analysis we have no idea what parts of treatment are being denied or not accessible to women of SES. Do they not have access to hysterectomy? Not have access to radiation? At what state/histological types are women suffering the most from their SES or racial status?
   We agree with Reviewer #2 that this is an interesting finding warranted of further study. Based on the data available in the SEER dataset, we were unable to disaggregate our treatment adherence variable to each individual treatment modality and instead needed to create an aggregate measure of overall treatment adherence for first course of treatment. Because of this limitation of not having disaggregated treatment adherence information, we are unable to examine which specific modalities within treatment adherence that were associated with racial/ethnic or SES disparities (i.e., surgery, surgical staging, radiation, chemotherapy). The available data we used in our multivariate analysis indicated that Black, Latina, and American Indian or Alaska Native women had lower odds of receiving treatment that was adherent to NCCN guidelines after adjusting for SES, stage at diagnosis, histology, grade, age at diagnosis, and year of diagnosis. Additionally, we found that relative to the highest SES level there was a gradient effect in lower odds of receiving adherent treatment after adjusting for race/ethnicity, stage at diagnosis, histology, grade, age at diagnosis, and year of diagnosis. We hope to examine these racial/ethnic and SES disparities in future studies but for this study we have acknowledged this in our discussion about future research directions on page 15 lines 311-314. Specifically, we write: “Future research should explore what factors may mitigate or exacerbate these disparities such as insurance status, geographical location, access and barriers to treatment, physician specialty, physician bias, hospital volume, and hospital type (e.g., academic versus community).”

22. Line 319: Going beyond "Black and White" is not that notable; ideally, this paper would comply with the racial and ethnic guidelines as laid out by the NIH.
   We thank Reviewer #2 for this comment. We have updated this sentence on page 16 lines 328-331 to read “Hence, our study provides greater insight into racial-ethnic disparities in endometrial cancer treatment as we have included a range of racial-ethnic groups into our analysis that are reflective of the racial-ethnic diversity in the United States and works towards the disaggregation of racial-ethnic groups.”

Reviewer #3 Comments:

The authors have utilized the SEER data base to evaluate compliance of management according to the NCCN guidelines. With such a data base numerous items can be identified and differences noted as it is quite large; however, other items of interest are not available.
23. For instance does NCCN guidelines in this cancer affect prognosis?
   We thank Reviewer #3 for this query. Our study was designed to evaluate the association of
   race/ethnicity and socioeconomic status with adherence to NCCN guidelines for endometrial cancer, we
   did not seek to assess outcomes in prognosis for this study. We do however agree with Reviewer #3 that
   this is an important question and merits future research within this topic. However, in studies that we
   have cited in our paper that focus on other cancer sites there have been noted findings in differences in
   overall survival and disease-specific survival with adherence to treatment guidelines being associated
   with improved survival. While beyond the scope of this manuscript, we have another analysis under
   review examining the implications of adherence to NCCN guidelines with cause-specific survival for
   endometrial cancer.

24. Although grade was evaluated was the data the same for Type 1 and 2 cancers?
   We thank Reviewer #3 for this query. For this analysis we did not set out to observe differences between
   Type 1 and Type 2 cancers but rather focused on stage, histology, and grade. We are open to including
   this type of analysis in a revised version of this manuscript if the editors feel that it is essential to
   include but it may add to the length of the manuscript or require us to eliminate more essential data to
   meet the page limit.

25. Differences in treatment compliance is highly significant but the actual differences was only 4-5%
   (race evaluation). Is this really clinically significant?
   We thank Reviewer #3 for their comments and query. Our study was designed to evaluate the
   association of race/ethnicity and socioeconomic status with adherence to NCCN guidelines for
   endometrial cancer, we did not seek to assess the clinical relevance of these adherence rates. We do
   however agree with Reviewer #3 that this is an important question and merits future research within
   this topic. However, in studies that we have cited in our paper that focus on other cancer sites there
   have been noted findings in differences in overall survival and disease-specific survival with adherence
   to treatment guidelines being associated with improved survival. While beyond the scope of this
   manuscript, we would like to note that we have a separate manuscript that is currently under review
   that examines the association between adherence to treatment guidelines and survival.

26. Although both race and SES were independently significant in regards to treatment compliance
   were combinations evaluated ie Blacks are in a lower SES, could those in that category account
   for the poor compliance?
   We thank Reviewer #3 for this query. The analyses presented in this manuscript show that both race-
   ethnicity and socioeconomic status were independently associated with treatment adherence. In
   response to this query, we conducted post-hoc analyses examining the question of joint variation by
   race/ethnicity and socioeconomic status. In post-hoc analyses, we found that there was no significant
   interaction between race-ethnicity and SES. While race-ethnicity and SES are sometimes correlated, in
   this dataset we see that more than 50% of Black women in our sample are above the lowest SES
   category which highlights the heterogeneity of SES within our sample. While we see that Black women
   are overrepresented in the lowest SES category (38.8%) there is also a fair proportion of women in the
   other racial-ethnic categories represented within the lowest SES category (27.5% Latina, 30.2%
   American Indian or Alaska Native). Future studies are warranted that explicitly examine the joint
   associations of race/ethnicity and socioeconomic status on these patterns.

27. Is the higher SES in Asians the reason for better treatment compliance?
   Reviewer #3 raises a great question that we hope to examine in future studies. Within our results we
   saw that higher SES was associated with greater odds of receiving adherent treatment and Asians were
   more likely to receive adherent treatment relative to White women. One of the limitations of
   retrospective population-based studies such as ours is the inability to make causal assumptions. While
   we can say that both higher SES and Asian race was associated with treatment adherence, we cannot
   determine from our data whether the higher SES among Asians in our sample was the reason for
   greater treatment adherence.
The manuscript is well written and would publish after above addressed.
We thank Reviewer 3 for this feedback and helpful questions.

Statistics Editor Comments:
28. Table 1: Should clarify for the reader that (1) the Table refers to %s and (2) only the first row and the last column refer to %s that were adherent, the remaining entries refer to %s within a particular stratum and (3) whether these %s are based on the crude counts, or weighted to be more representative. Also, as supplemental, should show the actual counts within each entry. The study period is from 2006-2015. Why was the year of study not included in the analysis, since in Table 3 there was a weak, albeit statistically significant association of year vs adherence? What evidence is presented that the adherence rates or patient profiles (SES, Age, Stage etc.) remained invariant from 2006-2015, thus allowing aggregation regardless of year of study?

We thank the Statistical Editor for these suggestions and comments. We recognize that our previous Table 1 was very dense therefore we have made various changes in order to clarify the information presented in Table 1 that we hope will present clearer to the reader. First, we have edited Table 1 to be presented now in two separate tables. Table 1 on page 23 describes the demographic and cancer characteristics of endometrial carcinoma cases by race and ethnicity while Table 2 on page 24 describes the demographic and cancer characteristics of endometrial carcinoma cases with adherent treatment in our sample. Our previous Table 2 and 3 have been changed to Table 3 and 4 (on page 24 and 25) to account for this change in Table 1. Additionally, in both Tables 1 and Tables 2 we have specified in the notes that all data are n (%) and have included the crude counts throughout the tables. Additionally, as suggested by the Statistics Editor we have included year of diagnosis into both Table 1 and Table 2. While the patterns of adherence may change over time for a variety of reasons, and population characteristics (e.g., SES, age) can change too, we controlled for the population characteristics that could contribute to anticipated changes over time (e.g., SES, age). Additionally, the guidelines for adherence did not substantially change over the period we are observing in our study1,2,3 therefore we shouldn’t expect much variation in our treatment adherence rates and the disparities we observed in our treatment adherence rates.


29. Table 3: Need to include concise statement in footnote explaining the covariates included in each Model. The columns of p-values are redundant, since CIs are included with ORs. Should designate as aORs or adjusted ORs when applicable.

We thank the Statistical Editor for these suggestions. We have added a footnote in our table to detail which covariates were included in each model. Specifically, we write on page 26 in Table 4: “Model 1 includes only race and ethnicity. Model 2 includes only neighborhood SES, and Model 3 includes race and ethnicity, neighborhood SES, and all demographic and clinical covariates (age at diagnosis, stage at diagnosis, histology, grade, and year of diagnosis).” Additionally, we have removed the columns of p-values and have collapsed the OR and 95%CI columns into one column each so that it reads more clearly and notes any significant findings with the denoted symbols. Lastly, we have edited our table to note clearly which models have unadjusted and adjusted ORS.

Editorial Office Comments:
30. 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.

We agree to OPT-IN: Yes, please publish my point-by-point response letter.

31. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA). 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.

We have confirmed among all coauthors that we have nothing to disclose.

32. For studies that report on the topic of race or include it as a variable, 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). Race/ethnicity must have been collected in a formal or validated way. If it was not, it should be omitted. Authors must enumerate all missing data regarding race and ethnicity as in some cases, missing data may comprise a high enough proportion that it compromises statistical precision and bias of analyses by race.

We have included a sentence in both the methods and limitations sections of our manuscript that describes how race and ethnicity was collected in this dataset and limitations of this classification. Specifically, in our methods section on page 7 lines 135-141 we write: “Race-ethnicity was classified into six groups: non-Latina White (reference group), non-Latina Black, Latina, non-Latina Asian, non-Latina Native Hawaiian or Pacific Islander, and non-Latina American Indian or Alaska Native (henceforth White, Black, Latina, Asian, Native Hawaiian or Pacific Islander, and American Indian or Alaska Native). There were no multi-racial groups reported in the SEER dataset. Racial-ethnic variables for the SEER dataset are ascertained through medical records or administrative information as opposed to patient’s self-reported racial-ethnic identity.” Further, in our limitations section on page 17 lines 357-359 we write: “Additionally, since race-ethnicity of the patient was registry reported there may be some misclassification that is not accurate or aligned with the patient’s self-reported racial-ethnic identity.”

Use "Black" and "White" (capitalized) when used to refer to racial categories. The nonspecific category of "Other" is a convenience 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.

The use of “Black” and “White” has been edited and changed throughout our manuscript so that all mentions of racial/ethnic categories are capitalized. We do not use “Other” to describe any racial/ethnic group in this paper.

33. If applicable: In order for an administrative database study to be considered for publication in Obstetrics & Gynecology, the database used must be shown to be reliable and validated. In your response, please tell us who entered the data and how the accuracy of the database was validated. This same information should be included in the Materials and Methods section of the manuscript.
Our study used data from the Surveillance, Epidemiology, and End Results (SEER) database. The SEER national cancer registry assembles population-based cancer registries throughout the United States and includes incidence and mortality information on demographics, prognostic characteristics, and primary cancer treatment. We have included this sentence describing the accuracy, reliability, and validity of the database we used in our Methods section on page 6 lines 114-116.

34. 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 observational studies (ie, STROBE), observational studies using ICD-10 data (ie, RECORD), studies of diagnostic accuracy (ie, STARD). 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. We have followed STROBE guidelines, as appropriate and have included the STROBE checklist for our manuscript in our resubmission. Additionally, we have noted in our cover letter that we have followed STROBE guidelines.

35. 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. We did not use any reVITALize definitions in our manuscript.

36. 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 appendices) but exclude references. The main body of our manuscript is 22 pages (excluding references).

37. 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).

We have acknowledged all of the financial support we received for this study in our title page in both the Disclosure of Funding Received and Acknowledgements section on page 1 lines 27 and 31-35.

We did not use any manuscript preparation assistance and thus have not reported this in our paper.

All persons who contributed to the work are reported in our manuscript as co-authors.

Portions of this paper was accepted as a poster to the 3rd NCI Symposium on Cancer Health Disparities, April 16-17, 2020 in Bethesda, Maryland. However, participation in this symposium was cancelled due to COVID-19. We have noted this in the title page under Conference Presentations on page 1 lines 39-40. We would like to note that this symposium did contact us as they have rescheduled the symposium to a virtual format after considerations for COVID-19. Our paper was under review with this journal at the time that participation in the rescheduled virtual conference was offered and we pulled our abstract for inclusion with this rescheduled symposium in order to adhere to the guidelines set out by the journal.

38. 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.

We have reviewed the abstract to ensure that the information in the abstract is consistent with the reports in the results section.

In addition, the abstract length should follow journal guidelines. The word limit for Original Research articles is 300 words. Please provide a word count.

Our word count for our abstract is 300 words.

39. 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.

We have removed all abbreviations and acronyms in our title to adhere to these guidelines. Additionally, we have gone through our manuscript text to ensure that all abbreviations and acronyms used are spelled out at the first time of use and subsequently use abbreviations or acronyms. This is the case for the manuscript text, tables, figures, and supplemental material.

40. 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.

We have removed all uses of the virgule symbol (/) in sentences with words and have rephrased our manuscript text, tables, figures, and supplemental material to avoid using this symbol. Namely we have changed the following reoccurring words and abbreviations: Race/ethnicity to race-ethnicity, American Indian/Alaska Native to American Indian or Alaska Native, AI/AN to AIAN, TH/BSO to TH-BSO, RH/BSO to RH-BSO.

41. ACOG is moving toward discontinuing the use of "provider." Please replace "provider" throughout your paper with either a specific term that defines the group to which are referring (for example, "physicians," "nurses," etc.), or use "health care professional" if a specific term is not applicable.
We have removed all uses of “provider” and we have replaced this word with the use of “physicians” throughout the manuscript that more accurately describes the group we are referring to.

42. 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.

We do not use NNTb or NNTh within our manuscript.

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%).

We have gone through our manuscript and have standardized our use of p-values to not exceed three decimal places and do not exceed one decimal place for percentages.

43. Your manuscript contains a priority claim. 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.

We have removed this priority claim and have revised the text on page 4 lines 285-286 to read: “Our study is novel in that it examines neighborhood socioeconomic disparities in the understudied context of treatment adherence for endometrial cancer.”

44. 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.

We have reviewed the journal’s Table Checklist to ensure that our tables conform to the journal style.

45. Please review examples of our current reference style at http://ong.editorialmanager.com (click on the Home button in the Menu bar and then "Reference Formatting Instructions" document under "Files and Resources). Include the digital object identifier (DOI) with any journal article references and an accessed date with website references. Unpublished data, in-press items, personal communications, letters to the editor, theses, package inserts, submissions, meeting presentations, and abstracts may be included in the text but not in the reference list.

In addition, the American College of Obstetricians and Gynecologists' (ACOG) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite ACOG documents in your manuscript, be sure the reference you are citing is still current and available. If the reference you are citing has been updated (ie, replaced by a newer version), please ensure that the new version supports whatever statement you are making in your manuscript and then update your reference list accordingly (exceptions could include manuscripts that address items of historical interest). If the reference you are citing has been withdrawn with no clear replacement, please contact the editorial office for assistance (obgyn@greenjournal.org). In most cases, if an ACOG document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All ACOG documents (eg, Committee
Opinions and Practice Bulletins) may be found at the Clinical Guidance page at [https://www.acog.org/clinical](https://www.acog.org/clinical) (click on "Clinical Guidance" at the top).

We have updated the references according to the Obstetrics & Gynecology Reference Style.

46. **Figure 1:** Please consider adding an exclusion box between the first two boxes.

We have included an exclusion box between the first two boxes of our Figure 1 on page 27.

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

*Our figure was created in Microsoft Word and we have submitted the original source file of this figure in our resubmission.*

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*We do not have any art saved in digital format in this manuscript.*

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

*Our figures were not created using any statistical programs.*

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

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*We do not have any art that is low resolution, digitized, adapted from slides, or downloaded from the Internet.*

47. 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.

*Our supplemental files have been renamed to “Appendix”, these supplemental files are “Supplementary Digital Content” not for print and therefore are not cited in the text.*

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