

OBSTETRICS & GYNECOLOGY



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

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

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obgyn@greenjournal.org.

Date: May 07, 2021
To: "Ally Murji" [REDACTED]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-21-771

RE: Manuscript Number ONG-21-771

Retrograde bladder filling following gynecologic surgery: a systematic review and meta-analysis

Dear Dr. Murji:

Your manuscript has been reviewed by the Editorial Board and by special expert referees. Although it is judged not acceptable for publication in Obstetrics & Gynecology in its present form, we would be willing to give further consideration to a revised version.

If you wish to consider revising your manuscript, you will first need to study carefully the enclosed reports submitted by the referees and editors. Each point raised requires a response, by either revising your manuscript or making a clear and convincing argument as to why no revision is needed. To facilitate our review, we prefer that the cover letter include the comments made by the reviewers and the editor followed by your response. The revised manuscript should indicate the position of all changes made. We suggest that you use the "track changes" feature in your word processing software to do so (rather than strikethrough or underline formatting).

Your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by May 28, 2021, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1:

This is a systematic review and meta-analysis of postop bladder retrofilling vs. passive filling following GYN surgery. The study is thorough and well done.

1. I would add in abstract results the fact that the shorter time to discharge did not apply to hysterectomies and also the fact that retrofilling in the PACU didn't work as well. These are important findings that should be in the abstract.
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No changes, easily understandable. Exclusion of studies appropriate, where retro filling occurred in both intervention and control groups.

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12 studies were included which was reduced to nine due to elective outpatient surgery criteria.

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Suggest to list the types of surgery with his technique, retro filling in the OR, would be most helpful such as, laparoscopic BSO, hysteroscopy, etc.

Explain how previous studies assessed if the patients adequately voided.

Overall extremely well written, easy to follow and understand. Forest plots were excellent. Thorough and detailed.

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This is a systematic review and meta-analysis of retrograde bladder filling following gynecologic surgery.

The topic was well defined and the primary outcome time to void is clearly defined as well.

There was a thorough literature review with a broad search that included a variety of databases and included all languages. I like how you outlined your search strategy, study protocol and included the PRISMA guideline for the reader. For line 108, I suggest you have a start date of the year that studies were included as opposed to writing from inception for clarity.

The inclusion criteria and study selection is clearly described with study quality and risk of bias assessed by the two independent reviewers reported. Randomized trials were included to increase the quality of the review. However, in the Table 1 or in the RESULTS section, it should be mentioned what type of RCTs were included. Were they blinded? Double blinded?

Other strengths include that authors of the studies were contacted for additional data where needed, as well as the calculation for statistical heterogeneity between studies. To improve clarity for the readers, in Line 160, please specify the score representing increased heterogeneity (ex: >50%)

My main comment to the author is regarding the choice to include patients who underwent procedures for stress urinary incontinence and pelvic organ prolapse. These patients represent a different patient population compared to other benign gynaecology patients with an increased risk of delayed voiding and urinary retention. Given that the primary outcome of the systematic review was stated to be time to first void in the context of enhanced recovery after surgery and the focus is on outpatient surgery (line 84-104), studies of inpatient urogynecology patients who had a trial of void on post-operative day 1 or 2 with a main focus of urinary retention (line 253-255) and not time to first void should be excluded from the review. In line 176 you state that combining the patients would lead to substantial heterogeneity. I agree that they should have been meta-analyzed separately. However, even further they should be excluded from this systematic review. Given that you meta-analyzed these patients separately, omitting this subset would not substantially change the review, meta-analysis, main results and conclusions.

STATISTICS EDITOR COMMENTS:

Fig 2, 3: Although mathematically correct, should round the estimates and CI for mean differences in minutes to the nearest 0.1 minute, not .01 minute precision. That would seem to be more clinically relevant.

Fig 4: Although the RR is NS, the power is limited, since urinary retention is uncommon. Based on the sample sizes and a rate of urinary retention of (67/480) 14% in the control group, and using 80% power and an alpha = 0.05, the discernable rate in the retro fill group would have to be < 8.0% or > 21%. Put another way, there was only ~ 50% power to discern a difference between 14% and 48/470 (10.2%). Would need a larger study to generalize the conclusion.

Fig 5: Similar issue for this RR in terms of stats power to discern differences in small rates. The data are not given, but from the RR = 0.50, with 95% CI = 0.14-1.77, the counts of UTIs appears to be much less than for urinary retention, thus the stats issues are more exaggerated.

EDITOR COMMENTS:

The Conclusions and tone of the manuscript should reflect the modest reductions in time first void and hospital discharge: 30 min is not that dramatic

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). Please check with your coauthors to confirm that the disclosures listed in their eCTA forms are correctly disclosed on the manuscript's title page. Each of your coauthors received an email from the system, titled "Please verify your authorship for a submission to Obstetrics & Gynecology." Each author should complete the eCTA if they have not yet done so.

3. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology has adopted the use of the reVITALize definitions. Please access the obstetric 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.

4. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Review articles should not exceed 6,250 words. Stated word limits include the title page, précis, abstract, text, tables, boxes, and figure legends, but exclude references.

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

- * All financial support of the study must be acknowledged.
- * Any and all manuscript preparation assistance, including but not limited to topic development, data collection, analysis, writing, or editorial assistance, must be disclosed in the acknowledgments. Such acknowledgments must identify the entities that provided and paid for this assistance, whether directly or indirectly.
- * All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors, must be acknowledged. Written permission must be obtained from all individuals named in the acknowledgments, as readers may infer their endorsement of the data and conclusions. Please note that your response in the journal's electronic author form verifies that permission has been obtained from all named persons.
- * If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted (include the exact dates and location of the meeting).
- * If your manuscript was uploaded to a preprint server prior to submitting your manuscript to Obstetrics & Gynecology, add the following statement to your title page: "Before submission to Obstetrics & Gynecology, this article was posted to a preprint server at: [URL]."

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

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

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

8. The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.

9. 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%).

10. 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.

11. 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).

12. Figures 1-5: Please upload as a figure files on Editorial Manager.

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.

13. 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.

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You will be receiving an Open Access Publication Charge letter from the Journal's Publisher, Wolters Kluwer, and instructions on how to submit any open access charges. The email will be from publicationservices@copyright.com with the subject line 'Please Submit Your Open Access Article Publication Charge(s)'. Please complete payment of the Open Access charges within 48 hours of receipt.

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 May 28, 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.

May 24, 2021

John O. Schorge, MD
Associate Editor, Gynecology

Re: Manuscript Number: ONG-21-771

Dear John O. Schorge,

We thank the Editor and Reviewers for their comments and the opportunity to complete the revisions. The suggestions were greatly appreciated, and every effort was made to address each one resulting in a concise and compelling manuscript. Each comment has been addressed individually in the following letter with a comment and a description and location of the changes where applicable. Two copies of the manuscript have been submitted, one with the changes tracked and the other with changes accepted. Page and line numbering throughout this document are in reference to the tracked changes document. We confirm that we have read the Instructions of Authors. The revisions have been made in consultation with all authors, and all have given their approval to the final revised form.

We thank you very much for your consideration,

A handwritten signature in cursive script, appearing to read "Murji", enclosed in a thin black rectangular border.

Dr. Ally Murji, Corresponding Author
Mt. Sinai Hospital, Department of Obstetrics and Gynecology
[REDACTED]
Toronto, ON
[REDACTED]
Canada

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Title: Retrograde bladder filling following gynecologic surgery: a systematic review and meta-analysis

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RESPONSES TO REVIEWER/EDITOR COMMENTS

REVIEWER #1, POINT 1

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- A. Thank you for this comment. We have amended the abstract per the reviewer's comment.
- B. Page 2, Lines 74-77
- C. Added: "Bladder retrofilling did not shorten time to discharge when performed in the post-anesthetic care unit (MD -14.8 min; 95% CI: -62.6 to 32.9, 3 studies, 258 patients, I²=48%) or following laparoscopic hysterectomy (MD -26.0 min; 95% CI: -56.5 to 4.5, 5 studies, 657 patients, I²=64%)."

REVIEWER #1, POINT 2

Methods: My main comment is why bothering to include the studies that evaluated inpatient trials of void. It doesn't seem to go with the other results and findings and is a different study population.

- A. This issue was also raised by Reviewer #3. For this reason, we have decided to remove four studies evaluating inpatients. The exclusion of these studies does not compromise our initial PROSPERO protocol. Our main results are also unaffected by these exclusions.
- B. Changes were made in the appropriate sections: abstract, results, discussion, PRISMA flow diagram, Table 1, and Figures 4 & 5. See revised manuscript with tracked changes.

REVIEWER #2, POINT 1

Retrograde bladder filling following gynecologic surgery: a systematic review and meta-analysis. The objective was to review and meta-analyze RCTs comparing postoperative bladder retrofilling to passive filling following gynecologic surgery.

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and background for the study. I don't have any recommendations to change the introduction, and I would recommend not adding more as it would get too wordy.

A. Thank you for the positive comments.

REVIEWER #2, POINT 2

Sources: No changes, concise and clear.

A. Thank you. No changes made.

REVIEWER #2, POINT 3

Study selection: No changes, easily understandable. Exclusion of studies appropriate, where retro filling occurred in both intervention and control groups.

Their use of Cochrane risk of bias tool is appropriate. It was clearly stated there is just ethical methods and are very appropriate.

A. Thank you.

REVIEWER #2, POINT 4

Results: 12 studies were included which was reduced to nine due to elective outpatient surgery criteria. Figures 2, 3, 4: very clear use of forest plots and layout of previous studies

Figure 5: risk of bias, easily understood and well laid out. Good point about increased risk due to inadequate blinding.

A. Thank you. No changes made.

REVIEWER #2, POINT 5

Discussion: Line 290: if discharge time didn't change, why would earlier voiding make a difference in the big picture? It's clear the authors are not strongly recommending post operative bladder filling in this instance, but in these cases what would be the advantage to quicker time to first void?

- A. We appreciate that retrofilling the bladder in the operating room following laparoscopic hysterectomy did not result in a *statistically* significant decrease in time to discharge. However, the point estimate favors earlier discharge with retrofilling (mean difference 25.9 min shorter). The 95% CI means that discharge time can be as short as 57 minutes in the retrofill group but may also be up to only 5.3 minutes longer. As per the reviewer's observation, we may not be making a strong recommendation for retrofilling in this subgroup of patients, however, the established earlier time to first void may be associated with earlier mobilization – which may be advantageous. Early mobilization is the hallmark of hysterectomy ERAS protocols due to multiple established benefits.
- B. In keeping with the reviewer's sentiment, we have made the following changes to the manuscript which highlight the advantages of quicker time to first void.
 - a. Page 15, Lines 310-316: **“Although time to discharge was not reduced**, clinicians should not discount postoperative bladder filling for outpatient hysterectomy as it is a safe, simple intervention that facilitates a quicker time to first void. **This**

shorter time to void may result in earlier postoperative mobilization, the advantages of which have been well established in early recovery after surgery (ERAS) protocols.²¹ For these reasons, retrofilling should be considered as part of a multimodal approach for optimizing patients for postoperative recovery following hysterectomy.”

REVIEWER #2, POINT 6

Line 295: the authors are correct that PACU retro filling as additional burden to nursing staff, however, if retro filling in the OR then when the patient voids in the PACU the nurse still needs to access the voiding and often do a bladder scanner which does impact their time and energy. If a fill & pull is performed, by the PACU nurses then it does require their time and energy to do the filling but they do not need to do a bladder scanner or assess voiding other than looking at the output. So, the burden and time for the nurses maybe evened out?

- A. We agree with the reviewer that it is difficult for us to precisely quantify PACU nursing workload due to the individualized nature of protocols and pathways. As such we have tempered our initial statement and highlighted this limitation and changed the manuscript accordingly.
 - a. Pages 15-16, Lines 321-328: “PACU retrofilling also adds the additional burden of **bladder instillation** on nursing staff. With operating room protocols, surgical staff can easily and rapidly perform bladder retrofilling before removing the catheter, with negligible effect on operative time. **Nonetheless, it is difficult for us to generalize regarding PACU nursing burden as resource utilization and workload are closely linked to individual institutional recovery protocols and pathways.”**

REVIEWER #2, POINT 7

Line 317: recommend adding to that last sentence, that Urogyn procedures have a high rate of increased retention risk.

- A. In response to reviewers 1 and 3, we have removed four trials of inpatient urogyn procedures. We now only include a single trial where urogyn procedures were performed and have made changes to our discussion to reflect the increased risk of urinary retention in this population.
- B. DISCUSSION: Pages 16-17, Lines 344-350:
 - a. "With only one study evaluating patients **undergoing urogynecologic procedures, we were not able to confidently evaluate the value of bladder retrofilling in this population** that is at an increased risk of urinary retention. Future RCTs should systematically investigate the effect of bladder retrofilling on time to first void, hospital discharge, and **postoperative urinary retention** following urogynecologic procedures."

REVIEWER #2, POINT 8

Suggest to list the types of surgery with his technique, retro filling in the OR, would be most helpful such as, laparoscopic BSO, hysteroscopy, etc.

- A. We appreciate the reviewer's sentiment and agree that it would be informative to know exactly which types of surgery would benefit most from bladder retrofilling. With this aim, we report on five studies of laparoscopic hysterectomy only. The single included study with a primarily urogynae population is discussed, and the inability to confidently evaluate bladder retrofilling in this population is also discussed. The remaining two studies did not provide sufficient detail to break down further the benefit of bladder retrofilling by surgery type. Due to the limited detail within the available data, we are unable to perform additional post-hoc subgroup analyses.

REVIEWER #2, POINT 9

Explain how previous studies assessed if the patients adequately voided.

- A. We have added a column to Table 1 that describes how each study reported "voiding trial success criteria". We have also amended the results and limitations sections accordingly.
- B. RESULTS: Page 9, Lines 189-191 – Added: " When reported, the criteria for a successful voiding trial varied between studies and included minimum voided volumes, post-void residual (PVR) volumes, a combination of voided volume and PVR, or no set criteria."
- C. LIMITATIONS: Page 16, Lines 341-342 – "...and in the criteria used to determine voiding trial success."
- D. TABLE 1: see manuscript

REVIEWER #2, POINT 10

Overall extremely well written, easy to follow and understand. Forest plots were excellent. Thorough and detailed.

- A. Thank you for the positive comments

REVIEWER #3, POINT 1

This is a systematic review and meta-analysis of retrograde bladder filling following gynecologic surgery. The topic was well defined and the primary outcome time to void is clearly defined as well. There was a thorough literature review with a broad search that included a variety of databases and included all languages. I like how you outlined your search strategy, study protocol and included the PRISMA guideline for the reader.

- A. Thank you for the positive comments

REVIEWER #3, POINT 2

For line 108, I suggest you have a start date of the year that studies were included as opposed to writing from inception for clarity.

- A. We have made the have made the requested change in the abstract and again in the methods

REVIEWER #3, POINT 3

The inclusion criteria and study selection is clearly described with study quality and risk of bias assessed by the two independent reviewers reported. Randomized trials were included to increase the quality of the review. However, in the Table 1 or in the RESULTS section, it should be mentioned what type of RCTs were included. Were they blinded? Double blinded?

- A. The term single and double blind may be unclear to the reader as to which groups are being blinded (surgeon, patient, outcome assessors, PACU staff, statistician, etc). For this reason, we have clearly described who was blinded in the results sections. The types of RCTs is also mentioned.
- B. RESULTS: Page 9, Lines 186-188 - "Five trials retrofilled the bladder in the operating room and blinded the patient and outcome assessors. The remaining three trials retrofilled the bladder in the PACU and were unblinded. All of the included studies utilized a parallel design."

REVIEWER #3, POINT 4

Other strengths include that authors of the studies were contacted for additional data where needed, as well as the calculation for statistical heterogeneity between studies. To improve clarity for the readers, in Line 160, please specify the score representing increased heterogeneity (ex: >50%)

- A. A sentence has been added to indicated the various levels of heterogeneity
- B. Page 8, Lines 165-166 – "An I^2 of 0 to 50% was considered low, 50 to 75% moderate, and > 75% high heterogeneity."

REVIEWER #3, POINT 5

My main comment to the author is regarding the choice to include patients who underwent procedures for stress urinary incontinence and pelvic organ prolapse. These patients represent a different patient population compared to other benign gynaecology patients with an increased risk of delayed voiding and urinary retention. Given that the primary outcome of the systematic review was stated to be time to first void in the context of enhanced recovery after surgery and the focus is on outpatient surgery (line 84-104), studies of inpatient urogynecology patients who had a trial of void on post-operative day 1 or 2 with a main focus of urinary retention (line 253-255) and not time to first void should be excluded from the review. In line 176 you state that combining the patients would lead to substantial heterogeneity. I agree that they should have been meta-analyzed separately. However, even further they should be excluded from this systematic review. Given that you meta-analyzed these patients separately, omitting this subset would not substantially change the review, meta-analysis, main results and conclusions.

- A. The same comment was made by another reviewer. We have removed four trials which evaluated inpatients following urogynecologic procedures.
- B. Please refer to REVIEWER #1, POINT 2 for list of applicable change locations.

STATISTICS EDITOR COMMENTS

STATISTICS EDITOR, POINT 1

Fig 2, 3: Although mathematically correct, should round the estimates and CI for mean differences in minutes to the nearest 0.1 minute, not .01 minute precision. That would seem to be more clinically relevant.

- A. The forest plots and in text data have been edited to a single decimal place.

STATISTICS EDITOR, POINT 2

Fig 4: Although the RR is NS, the power is limited, since urinary retention is uncommon. Based on the sample sizes and a rate of urinary retention of (67/480) 14% in the control group, and using 80% power and an alpha = 0.05, the discernable rate in the retro fill group would have to be < 8.0% or > 21%. Put another way, there was only ~ 50% power to discern a difference between 14% and 48/470 (10.2%). Would need a larger study to generalize the conclusion.

- A. Agreed - We appreciate that our power to detect a wide range of possible effect sizes is constrained by the extent of the available data collection. We have reworded our results and discussion to clarify that although we do not have statistical evidence at alpha=.05 to reject the null hypothesis of group equality for the POUR and UTI outcomes based on this particular data collection, that absence of evidence is certainly not definitive evidence of absence, and that a larger data collection (powered to detect a pre-specified clinically meaningful group difference) is needed to validate our analyses to date.
- B. RESULTS: Pages 12-13, Lines 258-261 - "The POUR and urinary tract infection results should be interpreted with caution as there is limited statistical power to detect difference in these infrequent outcomes, a larger data and appropriately powered data collection would be required to validate our analysis."

STATISTICS EDITOR, POINT 3

Fig 5: Similar issue for this RR in terms of stats power to discern differences in small rates. The data are not given, but from the RR = 0.50, with 95% CI = 0.14-1.77, the counts of UTIs appears to be much less than for urinary retention, thus the stats issues are more exaggerated.

- A. Please refer to STATISTICS EDITOR, POINT 2

EDITOR, POINT 1

The Conclusions and tone of the manuscript should reflect the modest reductions in time first void and hospital discharge: 30 min is not that dramatic

- A. We agree that the 30-minute reduction in time to first void and discharge is not that dramatic and have made edits to reflect this.
- B. ABSTRACT: Page 4, Line 84 – added: “modestly”
- C. DISCUSSION: Pages 14-17
 - a. Lines 294-297 - removed the statements regarding mean differences and rephrased the comment.
 - b. Line 303 – removed "significantly", statement of the mean difference in time to void following laparoscopic hysterectomy, and rephrased sentence
 - c. Line 363 – "Retrofilling the bladder in the operating room following outpatient gynecologic surgery **modestly** reduces time to void and discharge with no increase in adverse events."

EDITORIAL OFFICE POINT 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.**

EDITORIAL OFFICE POINT 2

Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (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. Each of your coauthors received an email from the system, titled "Please verify your authorship for a submission to Obstetrics & Gynecology." Each author should complete the eCTA if they have not yet done so.

- A. Each author has completed the eCTA form and disclosures, no changes**

EDITORIAL OFFICE POINT 3

Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology has adopted the use of the reVITALize definitions. Please access the obstetric 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.

- A. Reviewed the standard definitions, no changes required.**

EDITORIAL OFFICE POINT 4

Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Review articles should not exceed 6,250 words. Stated word limits include the title page, précis, abstract, text, tables, boxes, and figure legends, but exclude references.

A. Word count = 3628

EDITORIAL OFFICE POINT 5

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

- A. All financial support of the study must be acknowledged.
 - a. All support has been acknowledged; no changes made**
- B. 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.
 - a. No manuscript preparation assistance to report, no changes made**
- C. 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.
 - a. No acknowledgments required, all contributors meet requirements for authorship, no changes made**
- D. 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).
 - a. No presentations at any organizational meetings**
- E. If your manuscript was uploaded to a preprint server prior to submitting your manuscript to Obstetrics & Gynecology, add the following statement to your title page: "Before submission to Obstetrics & Gynecology, this article was posted to a preprint server at: [URL]."
 - a. Manuscript has not been uploaded to a preprint server**

EDITORIAL OFFICE POINT 6

The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does

not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

A. Abstract changes have been made and reviewed for inconsistencies

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

A. Abstract word count: 296

EDITORIAL OFFICE POINT 7

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

A. All abbreviations are not used in the title or precis and are spelled out the first time they are used.

EDITORIAL OFFICE POINT 8

The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.

A. Text has been edited to avoid the virgule symbol

EDITORIAL OFFICE POINT 9

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.

A. Reviewed, completed.

If appropriate, please include number needed to treat for benefits (NNTb) or harm (NNT_h). When comparing two procedures, please express the outcome of the comparison in U.S. dollar amounts.

A. Number needed to treat for benefits or harm not applicable.

B. Cost analysis comparison expressed in USD

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%).

A. P values have been changed to not exceed three decimal places within the text.

EDITORIAL OFFICE POINT 10

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.

A. Checklist reviewed, table conforms to it

EDITORIAL OFFICE POINT 11

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.

A. References have been reviewed to conform to the current reference style

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).

B. We have confirmed that the ACOG Committee Opinion cited is the current version.

EDITORIAL OFFICE POINT 12

Figures 1-5: Please upload as a figure files on Editorial Manager.

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.

A. Figure guidelines have been reviewed

EDITORIAL OFFICE POINT 13

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

A. Relabelled appendixes and figures within them

B. Updated Figures within Appendix 2 with fewer decimals places and higher resolution images

EDITORIAL OFFICE POINT 14

- A. 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>.
- B. 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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