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

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

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

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

Questions about these materials may be directed to the Obstetrics & Gynecology editorial office: obgyn@greenjournal.org.
RE: Manuscript Number ONG-21-1947

Nationwide Estimates of Annual Inpatient and Outpatient Hysterectomies Performed in the United States

Dear Dr. Wright:

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).

Please be sure to address the Editor comments (see "EDITOR COMMENTS" below) in your point-by-point response.

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 Nov 23, 2021, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1:

Both databases are samples, this paper uses these samples to create a virtual larger number of encounters to abstract a virtual larger number as the probable actual number of procedures. No doubt this is statistically acceptable, but it does mean that the actual totals postulated are probably not particularly accurate.

No mention is made of ambulatory surgery centers not owned by hospitals. The paper should acknowledge that and if possible provide the number of hospital affiliated centers and the number of non-affiliated. Furthermore, what percentage of the non-affiliated provide outpatient hysterectomy. If these numbers are significant, then the number of minimally invasive hysterectomies would be even higher.

No mention is made of hysterectomy in the context of prolapse surgery. What percentage of the vaginal hysterectomies were only done as part of a larger procedure for prolapse. What of combined procedures, with minimally invasive hysterectomy and vaginal repair.

A generation of gynecologists well versed in abdominal and vaginal surgery have given way to a new generation well versed in minimally invasive techniques.

Your paper documents this well known and inevitable change.

Reviewer #2:

The authors present a well written analysis of current utilization rates of hysterectomy. This analysis provides a more complete picture of hysterectomy rates as previous similar studies were limited to the inpatient setting or were not representative of nationwide trends. The one recommendation I would make is to go further in separating the hysterectomies for "benign indications". It makes sense that many benign hysterectomies are decreasing in terms of utilization rates since there are many less invasive and effective options for indications such as fibroids and cervical
dysplasia. However, there have been significant predictions that the rate of prolapse surgery was going up, and it would be useful to determine if that is the case. It would also be useful to understand what variables are associated with utilization of each type of hysterectomy, especially abdominal hysterectomy; specifically is it being utilized in non-urban, non-academic centers where there may be a lack of fellowship trained personnel to perform laparoscopic or vaginal surgery.

Reviewer #3:
This is a research letter presenting descriptive data on the trends in hysterectomy utilization from 2016-2018. It uses a new data source that I've not yet seen in publication, the Nationwide Ambulatory Surgery Sample, which was previously not available, limiting ability to do such national quantification. The piece is interesting, but ultimately, the short data window of 2016-2018 and the constraints of the research letter format limit the takeaways from the study. I do think this data is important and publishable, but I question the chosen format. I think that the study would be more interesting as a full manuscript, whereby methods could be more clearly stated, and results more completely presented, in order to make a more substantive addition to the literature. The data are novel, but I found myself wanting to know more information about age, race, indication, inpatient/outpatient setting, etc. I also wanted more in terms of statistical testing of differences. While the error bars are on the figures, confidence intervals and statistical significance is not mentioned in the text. While I am excited to read the paper that comes out of this unique data source, I am not sure this research letter adequately accomplishes its stated objectives. I would encourage the authors to dive deeper into the data and reformat as a manuscript/original research submission to a journal.

- Introduction: The first sentence should ideally have a citation, though there may be limits on the number of references allowed in a research letter. Same for Lines 12-13. The two stated objectives are essentially the same thing and could be combined into one.
- Methods: A supplementary table of CPT/ICD codes utilized should be presented or a different publication of such a table referenced. The phrase "minimally-invasive" typically is inclusive of vaginal hysterectomy. I would recommend calling it "laparoscopic (traditional laparoscopy or robotic-assisted)" rather than minimally invasive, as this could be confusing. A supplementary table of ICD classification for indication and gynecologic cancer should be provided or referenced. The methods do not describe the statistical method utilized for calculating standard errors in the weighted sample, nor the statistical software used for analysis. Significance testing of differences by year is not mentioned.
- Results: "Encounter" is a confusing term. I know what the author is saying, but please rephrase. My main issue with the results is that there are multiple comments that hysterectomies increased or decreased, but no mention of the confidence intervals around the weighted estimates, nor the statistical significance of the observed changes. There is no mention of any demographic or clinical characteristics, particularly age and more specific indications (abnormal bleeding, prolapse, etc) beyond cancer vs benign. Lines 36-38 do not make sense at all, it says the greatest number of procedures were performed in both the fourth and second quarters. The text of the results adds little to the figures beyond the specific numbers for the data points, but it entirely omits 95% confidence intervals around the weighted estimates
- Discussion: Again, using the term "minimally invasive" to be exclusive of vaginal hysterectomy is confusing, would be better to refer to those as laparoscopic. Without confidence intervals and significance testing reported, the claims of increases and decreases are not well supported by the presented data. "so we cannot exclude the possibility that we did not capture all hysterectomies" - it is certain that all hysterectomies weren't captured in the data, this limitation should be rephrased to more clearly state that the weighted estimates are not exact and are subject to sampling and statistical error.

STATISTICS EDITOR COMMENTS:
Lines 36-38: Were those differences by quarter statistically significant? Were those differences due to the survey method or the reporting method for either the NIS or NASS?

Figs 1, 2 legends: Should include some summary of the key statistical differences over time.

EDITORIAL OFFICE COMMENTS:
1. The Editors of Obstetrics & Gynecology have increased 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. When you submit your revised manuscript, please make the following edits to ensure your submission contains the required information that was previously omitted for the initial double-blind peer review:

* Include your title page information in the main manuscript file. The title page should appear as the first page of the document. Add any previously omitted Acknowledgements (ie, meeting presentations, preprint DOIs, assistance from non-byline authors).
* Funding information (ie, grant numbers or industry support statements) should be disclosed on the title page and in the body text. For industry-sponsored studies, the Role of the Funding Source section should be included in the body text of the manuscript.
* Include clinical trial registration numbers, PROSPERO registration numbers, or URLs at the end of the abstract (if applicable).
* Name the IRB or Ethics Committee institution in the Methods section (if applicable).
* Add any information about the specific location of the study (ie, city, state, or country), if necessary for context.

2. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA), which must be completed by all authors. When you uploaded your manuscript, each co-author received an email with the subject, "Please verify your authorship for a submission to Obstetrics & Gynecology." Please check with your coauthors to confirm that they received and completed this form, and that the disclosures listed in their eCTA are included on the manuscript's title page.

3. Our journal requires that all evidence-based research submissions be accompanied by a transparency declaration statement from the manuscript's lead author. The statement is as follows: "The lead author* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained."
*The manuscript's guarantor.

If you are the lead author, please include this statement in your cover letter. If the lead author is a different person, please ask him/her to submit the signed transparency declaration to you. This document may be uploaded with your submission in Editorial Manager.

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

6. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Research Letters should not exceed 600 words and may include no more than two figures and/or tables (2 items total). Stated word limits include the title page, précis, abstract, text, tables, boxes, and figure legends, but exclude references.

7. 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]."

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

9. Provide a précis on the second page, for use in the Table of Contents. The précis is a single sentence of no more than 25 words that states the conclusion(s) of the report (ie, the bottom line). The précis should be similar to the abstract's conclusion. Do not use commercial names, abbreviations, or acronyms in the précis. Please avoid phrases like "This paper presents" or "This case presents."

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. 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").

13. 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.

14. 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 references you are citing are still current and available. Check the Clinical Guidance page at https://www.acog.org/clinical (click on "Clinical Guidance" at the top). If the reference is still available on the site and isn't listed as "Withdrawn," it's still a current document.

If the reference you are citing has been updated and 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.

15. 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.
16. 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.

17. 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.

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.

If you choose open access, you will receive 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 as a Microsoft Word document. 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 Nov 23, 2021, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,
John O. Schorge, MD
Associate Editor, Gynecology

2020 IMPACT FACTOR: 7.661
2020 IMPACT FACTOR RANKING: 3rd out of 83 ob/gyn journals

In compliance with data protection regulations, you may request that we remove your personal registration details at any time. (Use the following URL: https://www.editorialmanager.com/ong/login.asp?a=r). Please contact the publication office if you have any questions.
November 8, 2021

Re: “Nationwide Estimates of Annual Inpatient and Outpatient Hysterectomies Performed in the United States” (ONG-21-1947)

Dear Dr. Schorge:

Thank you for the opportunity to submit our work to Obstetrics & Gynecology. We appreciate the comments provided by you and your Reviewers. Below, please find point-by-point responses to each of the comments raised.

Reviewer #1

1. Both databases are samples, this paper uses these samples to create a virtual larger number of encounters to abstract a virtual larger number as the probable actual number of procedures. No doubt this is statistically acceptable, but it does mean that the actual totals postulated are probably not particularly accurate.

We agree with the Reviewer’s comment. In our limitations section we specifically acknowledge this point: “The NIS and NASS sampling schema is meant to provide national estimates from a sample of the U.S. population, so we cannot exclude the possibility that we did not capture all hysterectomies.” Additionally, we have provided a flow diagram describing how our current sample was extrapolated.

2. No mention is made of ambulatory surgery centers not owned by hospitals. The paper should acknowledge that and if possible provide the number of hospital affiliated centers and the number of non-affiliated. Furthermore, what percentage of the non-affiliated provide outpatient hysterectomy. If these numbers are significant, then the number of minimally invasive hysterectomies would be even higher.

We appreciate the Reviewer’s comment and acknowledge that some free standing surgical centers may not have been sampled.

3. No mention is made of hysterectomy in the context of prolapse surgery. What percentage of the vaginal hysterectomies were only done as part of a larger procedure for prolapse. What of combined procedures, with minimally invasive hysterectomy and vaginal repair.

We suspect and our prior work has demonstrated that a large proportion of vaginal hysterectomies performed in the U.S. are for urogynecologic indications. Given the word limitations of the current analysis a priori we chose to stratify our sample based on benign or malignant indications without a further breakdown of specific indications for surgery.

4. A generation of gynecologists well versed in abdominal and vaginal surgery have given way to a new generation well versed in minimally invasive techniques. Your paper documents this well known and inevitable change.
We concur with the Reviewer’s comment. Clearly patterns of care for hysterectomy has changed and shifted to MIS hysterectomy. One point of our work is to highlight this fact.

**Reviewer #2**

1. The authors present a well written analysis of current utilization rates of hysterectomy. This analysis provides a more complete picture of hysterectomy rates as previous similar studies were limited to the inpatient setting or were not representative of nationwide trends. The one recommendation I would make is to go further in separating the hysterectomies for "benign indications". It makes sense that many benign hysterectomies are decreasing in terms of utilization rates since there are many less invasive and effective options for indications such as fibroids and cervical dysplasia. However, there have been significant predictions that the rate of prolapse surgery was going up, and it would be useful to determine if that is the case. It would also be useful to understand what variables are associated with utilization of each type of hysterectomy, especially abdominal hysterectomy; specifically is it being utilized in non-urban, non-academic centers where there may be a lack of fellowship trained personnel to perform laparoscopic or vaginal surgery.

We appreciate the Reviewer’s comment. Given the word limitations of the research letter format we did not provide extensive modeling of factors associated with each route of surgery. There is a relatively large body of literature describing factors associated with various routes of hysterectomy and disparities in access to minimally invasive surgery.

**Reviewer #3**

1. This is a research letter presenting descriptive data on the trends in hysterectomy utilization from 2016-2018. It uses a new data source that I've not yet seen in publication, the Nationwide Ambulatory Surgery Sample, which was previously not available, limiting ability to do such national quantification. The piece is interesting, but ultimately, the short data window of 2016-2018 and the constraints of the research letter format limit the takeaways from the study. I do think this data is important and publishable, but I question the chosen format. I think that the study would be more interesting as a full manuscript, whereby methods could be more clearly stated, and results more completely presented, in order to make a more substantive addition to the literature. The data are novel, but I found myself wanting to know more information about age, race, indication, inpatient/outpatient setting, etc. I also wanted more in terms of statistical testing of differences.

We appreciate the Reviewer’s comment. We agree that NASS is a novel data source and there are many potential applications. We believe that an important and unanswered question is the number of hysterectomies performed each year in the U.S. A priori the goal of our analysis was simply to quantitate the annual number of procedures performed. As the Reviewer notes, we only have data from 2016-2018 and it will be of great value to add additional years of data as they become available.

2. While the error bars are on the figures, confidence intervals and statistical significance is not mentioned in the text. While I am excited to read the paper that comes out of this unique data
source, I am not sure this research letter adequately accomplishes its stated objectives. I would encourage the authors to dive deeper into the data and reformat as a manuscript/original research submission to a journal.

While we agree that there are many potential avenues of inquiry, the goal of this work was very focused, to estimate the annual number of hysterectomies performed in the U.S. As such, we believe that the study is well suited as a Research Letter.

3. Introduction: The first sentence should ideally have a citation, though there may be limits on the number of references allowed in a research letter. Same for Lines 12-13. The two stated objectives are essentially the same thing and could be combined into one.

A citation has been added as suggested.

4. Methods: A supplementary table of CPT/ICD codes utilized should be presented or a different publication of such a table referenced. The phrase "minimally-invasive" typically is inclusive of vaginal hysterectomy. I would recommend calling it "laparoscopic (traditional laparoscopy or robotic-assisted)" rather than minimally invasive, as this could be confusing. A supplementary table of ICD classification for indication and gynecologic cancer should be provided or referenced.

A supplemental table of CPT and ICD-10 codes for the analysis has been included. Numerous prior publications have grouped hysterectomy as abdominal, minimally invasive and vaginal and we have thus chosen to retain this classification.

5. The methods do not describe the statistical method utilized for calculating standard errors in the weighted sample, nor the statistical software used for analysis. Significance testing of differences by year is not mentioned.

We have added the statistical methodology and software utilized as suggested. Differences in the performance of hysterectomy by year and quarter were estimated using Rao-Scott chi-square tests to account for the complex sampling schema.

6. Results: "Encounter" is a confusing term. I know what the author is saying, but please rephrase.

An important limitation of NIS and NASS is that individual records are de-identified and thus one patient may have multiple encounters. Certainly, for hysterectomy this should not be an issue, but AHRQ specifically recommends not referring to individual records as patients.

7. My main issue with the results is that there are multiple comments that hysterectomies increased or decreased, but no mention of the confidence intervals around the weighted estimates, nor the statistical significance of the observed changes. There is no mention of any demographic or clinical characteristics, particularly age and more specific indications (abnormal bleeding, prolapse, etc) beyond cancer vs benign.
We have added tests of statistical significance for changes in the number of procedures over time. As described above, the goal of this analysis was to report nationwide estimates and not to provide an in depth analysis of clinical or demographic factors associated with various routes of surgery. Confidence intervals are displayed in the figure.

8. Lines 36-38 do not make sense at all, it says the greatest number of procedures were performed in both the fourth and second quarters.

The text states: “the greatest number of procedures were performed in the fourth quarter while the second quarter saw the second highest number of procedures.”

9. The text of the results adds little to the figures beyond the specific numbers for the data points, but it entirely omits 95% confidence intervals around the weighted estimates.

The confidence intervals are displayed in the Figures and we chose not to repeat in the text. We have added tests of statistical significance to highlight differences over time in our findings.

10. Discussion: Again, using the term "minimally invasive" to be exclusive of vaginal hysterectomy is confusing, would be better to refer to those as laparoscopic. Without confidence intervals and significance testing reported, the claims of increases and decreases are not well supported by the presented data. "so we cannot exclude the possibility that we did not capture all hysterectomies" - it is certain that all hysterectomies weren't captured in the data, this limitation should be rephrased to more clearly state that the weighted estimates are not exact and are subject to sampling and statistical error.

We have rephrased the limitation of undercapture of hysterectomies as suggested.

**STATISTICS EDITOR COMMENTS**

Lines 36-38: Were those differences by quarter statistically significant? Were those differences due to the survey method or the reporting method for either the NIS or NASS?

The changes over time by quarter and year were statistically significantly different. Statistical methodology and P-values have been added to the text.

Figs 1, 2 legends: Should include some summary of the key statistical differences over time.

Statistical testing has been performed and added for the figures as suggested.

**EDITORIAL OFFICE COMMENTS**

1. The Editors of Obstetrics & Gynecology have increased 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.

Opt-In

2. When you submit your revised manuscript, please make the following edits to ensure your submission contains the required information that was previously omitted for the initial double-blind peer review:
   
   * Include your title page information in the main manuscript file. The title page should appear as the first page of the document. Add any previously omitted Acknowledgements (ie, meeting presentations, preprint DOIs, assistance from non-byline authors).
   * Funding information (ie, grant numbers or industry support statements) should be disclosed on the title page and in the body text. For industry-sponsored studies, the Role of the Funding Source section should be included in the body text of the manuscript.
   * Include clinical trial registration numbers, PROSPERO registration numbers, or URLs at the end of the abstract (if applicable).
   * Name the IRB or Ethics Committee institution in the Methods section (if applicable).
   * Add any information about the specific location of the study (ie, city, state, or country), if necessary for context.

The manuscript has been updated accordingly.

2. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA), which must be completed by all authors. When you uploaded your manuscript, each co-author received an email with the subject, "Please verify your authorship for a submission to Obstetrics & Gynecology." Please check with your coauthors to confirm that they received and completed this form, and that the disclosures listed in their eCTA are included on the manuscript's title page.

The eCTAs will be provided.

3. Our journal requires that all evidence-based research submissions be accompanied by a transparency declaration statement from the manuscript's lead author. The statement is as follows: "The lead author* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained." *The manuscript's guarantor.

If you are the lead author, please include this statement in your cover letter. If the lead author is a different person, please ask him/her to submit the signed transparency declaration to you. This document may be uploaded with your submission in Editorial Manager.

Dr. Wright affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any
discrepancies from the study as planned (and, if relevant, registered) have been explained.

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

The study adhered to the STROBE guidelines

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

Only standard definitions were utilized.

6. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Research Letters should not exceed 600 words and may include no more than two figures and/or tables (2 items total). Stated word limits include the title page, précis, abstract, text, tables, boxes, and figure legends, but exclude references.

The study adheres to the word count limitations.

7. 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]."

There are no acknowledgements.

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

Annual Hysterectomy Rates in the U.S.

9. Provide a précis on the second page, for use in the Table of Contents. The précis is a single sentence of no more than 25 words that states the conclusion(s) of the report (ie, the bottom line). The précis should be similar to the abstract's conclusion. Do not use commercial names, abbreviations, or acronyms in the précis. Please avoid phrases like "This paper presents" or "This case presents."

A Precis has been added.

10. Only standard abbreviations and acronyms are allowed. A selected list is available online at [http://edmgr.ovid.com/ong/accounts/abbreviations.pdf](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.

Only standard abbreviations are utilized.

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.

The virgule is not utilized.

12. 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").

Not applicable.

13. 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.

Not applicable.

14. 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 references you are citing are still current and available. Check the Clinical Guidance page at https://www.acog.org/clinical (click on "Clinical Guidance" at the top). If the reference is still available on the site and isn't listed as "Withdrawn," it's still a current document.

If the reference you are citing has been updated and 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.

The references are in compliance with recommendations.
15. 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 (e.g., 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.

The figures have been uploaded to Editorial Manager as suggested.

16. 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.

The supplemental content has been added as described above.

17. 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](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](https://wkauthorservices.editage.com/open-access/hybrid.html).

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.

If you choose open access, you will receive 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.

We will publish via the subscription route.

Again, thank you for the opportunity to submit our work. If I can be of further assistance please don’t hesitate to contact me.

Sincerely,

Jason D. Wright, M.D.