

Author's response to reviews

Title: A Multicenter Review of Deep Venous Thrombosis Prophylaxis Practice Patterns for Blunt Hepatic Trauma

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Author's response to reviews:

Dear Dr. Ekkernkamp,

Thank-you so much for your kind review of our manuscript entitled "A multicenter review of deep venous thrombosis prophylaxis practice patterns for blunt hepatic trauma." We have edited the manuscript in an effort to address each of the reviewer's comments (both minor essential and discretionary). More specifically:

Minor Essential:

1. We have corrected the word "blunt" in the Methods and Results section (Page 4, Line 13).
2. We have also corrected the word "is" in the Conclusion section (Page 10, Line 6).

Discretionary:

3. Because this study is retrospective in nature, we are unable to comment on the precise reason that a given surgeon/clinician may have decided not to utilize chemical DVT prophylaxis. Based on the observation that 80% of all patients with high (III, IV, V) grade liver injuries received delayed prophylaxis, compared to only 34% with low grade injuries, we believe that it was related to a clinician's desire to ensure peri-admission success of a non-operative therapeutic approach. Your query is something that highlights the very heart of this research question! We have therefore added a specific comparator sentence to highlight these differences in the Discussion section (Page 8, Lines 19-21). Additionally, the reason for the observed difference in length of stay, despite similar ISS, in patients with low grade liver injuries, is unclear to us.

4. The 18% rate of identified DVTs in our study is certainly lower than the published potential incidence of 50%. We believe this is a direct result of differences in screening methodology in both data sets. In the studies that outline the up to 50% rate, routine ultrasound screening was employed in all patients to define a true incidence. In our patient cohort, only those patients who had a “clinical suspicion” were scanned. Therefore, our true incidence may have actually been much higher (had our methodology been to screen all patients prospectively). We have added this concept to the Discussion section (Page 9-10, Lines 21-23, Lines 1-2 respectively).

5. The presence of traumatic brain injuries is a significant confounding factor for most clinicians when trying to decide when to start chemical prophylaxis. While we tend to initiate chemical prophylaxis on post-admission day 1 at our institution (assuming the clinical exam and repeat CT of the brain are stable), this practice is based on a small amount of retrospective data. As a result, we are now conducting a prospective study to evaluate this particular injury pattern. Unfortunately, it will not be completed until 2010.

6. Thank-you for this excellent question. We did in fact compile our data and perform a subsequent statistical analysis. When our observations and conclusions were unchanged, we felt that it was better to be as specific as possible in describing our cohorts, and therefore we presented each group in its most pure form.

Thank-you again for your assistance and comments in reviewing our manuscript. I hope we have thoroughly addressed each of the reviewer’s comments in our revisions. We look forward to assisting in any additional manner possible.

Sincerely,

Chad Ball, on behalf of all co-authors