Author's response to reviews

Title: Cut throat injuries at a University teaching hospital in northwestern Tanzania: A review of 98 cases

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Author's response to reviews: see over
Author's response to reviews

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Author's response to reviews: See over
Reviewer's report
Title: Cut throat injuries at a University teaching hospital in northwestern Tanzania: A prospective review of 98 cases
Version: 1 Date: 23 May 2013
Reviewer: Neville Shine

Reviewer's report:
Overall the submitted article has some minor and major flaws and would require significant revision to be acceptable for publication.

Major
1. The introduction is unnecessarily extensive and the majority would be more appropriately put in the discussion section including the following:
   “The incidence of cut throat injuries irrespective of the cause is on the increase worldwide [3]. Globally, approximately 5% to 10% of all trauma involves penetrating neck trauma, with multiple structures being injured in 30% of patients [4-7]. The problem is increasing at a fast rate in developing countries partly because of increasing conflict over limited resources, poor socioeconomic status, poverty, unemployment, easy access to firearms, alcohol and substance misuse and increased crime rates [8]. The etiology of cut throat injuries can be broadly divided into suicidal, homicidal or accidental in occurrence [3, 9]. Familial troubles, psychiatric illnesses and poverty are documented triggering factors in suicidal attempts. The triggering factors for homicide are political conflict, familial, land related disputes and sex related crimes [9, 10, 11]. Regarding accidental causes mostly related to the road traffic accident and fall injuries [10].

   Anatomically, the neck can be divided into three major zones in order to aid in the decision making for diagnostic tests and timing of surgery [9, 13]. Zone I injuries occur at the thoracic outlet, which extends from the level of the cricoid cartilage to the clavicles. Zone II injuries occur in the area between the cricoid and the angle of the mandible. Injuries here are the easiest to expose and evaluate. Zone III injuries are between the angle of the mandible and the base of the skull. Although zones I and III are protected by bones and the vital structures in the zone II are not protected by bone, so the risk of injury is different in three zones [9-13].

   Cut throat injuries may be fatal if major blood vessels of the neck are involved, resulting in hemorrhage and hypovolaemic shock or if there is aspiration of blood or severe airway obstruction from edema and fractured laryngeal skeleton [4-7, 9]. These injuries pose a great challenge because multiple vital structures are vulnerable to injuries in the small, confined unprotected area [9]. Up to 30% of the injuries involve multiple structures [4-7].

   The management of these injuries requires a multidisciplinary approach and could be managed with better prognosis if the patients present early to the hospital and are given prompt attention.

   This requires the close collaboration of the Otolaryngologist, the anesthetist and the psychiatrist [11, 14, 15]. The anesthetist secures an uncompromised airway and makes sure the patient is breathing; the otolaryngologist assesses the injury and repairs the severed tissues with the aim of restoration of swallowing, phonation and breathing. The psychiatrist provides adequate care and supervision during and after surgical treatment [9, 11, 14, 15]. However, in most developing countries such as Tanzania, late
presentation to health facilities coupled with lack of advanced pre-hospital and ineffective ambulance system for transportation of patients to hospital care contributes significantly to increasing morbidity and mortality [9, 16, 17].”

**We agree with the reviewer that the background section of this manuscript is unnecessarily extensive and the majority would be more appropriately put in the discussion section. However, we would like this section to remain as it is because shifting this portion to the discussion section will also make this section (discussion) unnecessarily extensive. We have also omitted the word “prospective” in the title as the study had both prospective and retrospective component. It should now read “ ........... : a review of 98 cases and not ....”a prospective review of 98 cases”**

In the methods section there are several minor and major issues.

**Minor**

2. Firstly the following description is overly verbose and unwarranted: “BMC is a referral, consultant and teaching hospital for the Catholic University of Health and Allied Sciences-Bugando (CUHAS-Bugando) and other paramedics and it is located in Mwanza city in the northwestern part of the United Republic of Tanzania. It is situated along the shore of Lake Victoria and has 1000 beds. BMC is one of the four largest referral hospitals in the country and serves as a referral centre for tertiary specialist care for a catchment population of approximately 13 million people from neighboring. There is no trauma centre or established advanced pre-hospital care in Mwanza city as a result all trauma patients are referred to BMC for expertise management.”

**We would also like this part of the methods section to remain unchanged as we thought description of study area (setting) is of paramount important in this study**

**Major**

3. “Patients who presented to the A & E department between October 2010 and January 2013 were prospectively enrolled in the study after signing an informed written consent for the study.” This statement is somewhat confusing. Was it only patients with penetrating neck injuries who signed consent that were included? If so, how many patients with neck injuries who did not sign were excluded? Also, as some patients presented in a “shocked” state, how was the informed consent acquired? Some patients were under 18, who consented for these patients? How was retrospective consent acquired for those included retrospectively? If only those patients who were available for retrospective consent, how many were unavailable?

**To avoid confusion, inclusion and exclusion criteria is clearly described in the revised manuscript**

4. “All recruited patients were first resuscitated in the A&E department according to Advanced Trauma Life Support (ATLS).” This sounds as if recruitment preceded resuscitation. Clarification is required.
To avoid confusion, clarification has been done in the revised manuscript

5. “An informed written consent was sought from patients / relatives who were recruited prospectively.” Please clarify at which point the consent was performed.

The point at which the consent was performed is clearly stated in the revised manuscript

6. “During the period of study, a total of 98 patients with cut throat injuries were enrolled into the Study” Please clarify inclusion and exclusion criteria and total number of presentations of penetrating neck injuries both included and excluded over the study period.

The inclusion and exclusion criteria and total number of presentations of penetrating neck injuries both included and excluded over the study period is clearly stated in the revised manuscript

7. “Of these, 12 (12.2%) patients were studied retrospectively” How was the retrospective period of analysis defined and why? There seems to be no logical reason to pick these patients to be retrospectively analyzed and not continue the retrospective analysis further or indeed exclude them completely from the review.

The retrospective period of analysis is clearly defined in the revised manuscript

8. The results are largely presented in table format. It is interesting that the Authors’ documented no neural injuries although the need for permanent tracheostomy and voice change would suggest recurrent laryngeal nerve damage but it is not documented either at surgical exploration or clinical evaluation of vocal cord function.

The documentation of anatomical damage, site and extent would be of the utmost interest to the practicing surgeon and is only given superficial treatment. “the remaining 3 (3.4%) patients were discharged with permanent disabilities related to permanent tracheostomy and permanent voice change”

In this study, because of inclusion of patients retrospectively, no documentation was reported to suggest recurrent laryngeal nerve damage and this has been clearly stated as a study limitation

9. “This has great economic impact since these are people in their most productive years and the injuries impose a considerable burden on their families and the society as a whole. The fact that the economically productive age-group were mostly involved demands an urgent public policy response.” This statement is profoundly disturbing as the authors present the thesis that the economic potential of the predominant age and gender group in the study under review is what demands an “urgent policy response”.

In this study, because of inclusion of patients retrospectively, no documentation was reported to suggest recurrent laryngeal nerve damage and this has been clearly stated as a study limitation
Surely it is the doctors role to advocate for all patients regardless of race, gender, age or socio-economic circumstance and the authors assertion should be withdrawn. Finally, it is unclear as to where logistic regression analysis has been applied to the data. Please clarify

We agree with the reviewer, to avoid confusion, the statement “The fact that the economically productive age-group were mostly involved demands an urgent public policy response” has been omitted in the revised manuscript. Multivariate logistic regression analysis has been applied to determine the predictors of mortality and length of hospital stay

Level of interest: An article of limited interest
Quality of written English: Needs some language corrections before being published
Statistical review: No, the manuscript does not need to be seen by a statistician.
Declaration of competing interests:
No competing interests

Reviewer’s report
Title: Cut throat injuries at a University teaching hospital in northwestern Tanzania: A prospective review of 98 cases
Version: 1 Date: 17 June 2013
Reviewer: Javad Salimi
Reviewer's report:
Minor Essential revision

In agreement with the reviewer, minor essential revision has been made in the revised manuscript

Level of interest: An article of importance in its field
Quality of written English: Acceptable
Statistical review: Yes, but I do not feel adequately qualified to assess the statistics.

Reviewer's report
Title: Cut throat injuries at a University teaching hospital in northwestern Tanzania: A prospective review of 98 cases
Version: 1 Date: 19 June 2013
Reviewer: Pradeep Navsaria
Reviewer's report:
1. Is the question posed by the authors well defined? Yes
2. Are the methods appropriate and well described? Yes
3. Are the data sound?
Yes
4. Does the manuscript adhere to the relevant standards for reporting and data deposition?
Yes
5. Are the discussion and conclusions well balanced and adequately supported by the data?
Yes
6. Are limitations of the work clearly stated?
Yes
7. Do the authors clearly acknowledge any work upon which they are building, both published and unpublished?
No
8. Do the title and abstract accurately convey what has been found?
Yes
9. Is the writing acceptable?
Yes

We thank the reviewer for accepting our manuscript without any revision

**Level of interest:** An article of importance in its field  
**Quality of written English:** Acceptable  
**Statistical review:** No, the manuscript does not need to be seen by a statistician.