Author's response to reviews

Title: Seroprevalence of Hepatitis A Infection in A Low Endemicity Country: A Systematic Review

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Version: 3 Date: 29 June 2005

Author's response to reviews: see over
June 28, 2005

To:

Dr Peter Newmark,  
Editor-in-Chief,  
and The BioMed Central Editorial Team,  
BioMed Central Infectious Diseases Journal

Dear Dr. Newmark and colleagues,

RE: Manuscript 9010747869234093: “Seroprevalence of hepatitis A infection in a low endemicity country: a systematic review”

Thank you very much for your email dated June 21, 2005 and the included peer reviews. We are very pleased that BioMed Central Infectious Diseases Journal found our manuscript acceptable for publication with discretionary revisions.

We have carefully reviewed the excellent suggestions made by the two reviewers and have revised the manuscript accordingly as requested. We also have re-formatted the manuscript using your “Manuscript formatting checklist”. This updated version of the manuscript has been uploaded on your website. Further, as you requested, we have enclosed a table with a point by point reply to the various recommendations of the referees, and have also indicated where any changes have been made (enclosed below).

Please address all correspondence to: Ba’ Pham, Biostatistics and Epidemiology Group, BioMedical Data Sciences, GlaxoSmithKline Canada, 7333 Mississauga Road N., Mississauga, Ontario, Canada L5N 6L4, Tel.: 905 403 4478, Fax: 905 829 6065, Email: ba.z.pham@gsk.com.

Thank you very much for your review and consideration of our manuscript.

Yours sincerely,

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BioMedical Data Sciences  
GlaxoSmithKline, Canada
Reviewer’s Comments and Responses: *BioMed Central Infectious Diseases Journal* Manuscript # 9010747869234093

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<th>Reviewer #</th>
<th>Comments</th>
<th>Responses</th>
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| Reviewer #1 Ms. Janaki Amin | • Include appendix 1 as a table in the document.  
• Include in this table if study data included that for HAV vaccinated people.  
• Leave out appendix 2 and explicitly state exclusion criteria in the methods.  
• Table 2: include a column which states which AORs were adjusted for (e.g., age, sex) or if all were adjusted for then state this in the methods and in the footnote.  
• Be consistent with sub-headings in the results or don’t use any.  
• Label the x-axis on figure 2 | • We included Table 1 with content from the previous Appendix 1 (p. 20)  
• We footnoted three studies reporting on prevalence data for individuals with and without vaccination (Table 1, page 20).  
• We described the way we categorized the reasons for exclusion in the Methods section (page 5) by writing the following “Reasons for exclusion were categorized and reported”. We also reported common reasons for exclusion in the Results section (page 6), which was written as “Common reasons for exclusion at the screening stage included studies of hepatitis B virus (n=95), hepatitis C virus (n=64), commentaries (n=24), and others (n=121; Figure 1). Common reasons for exclusion at the full-text review stage included general review of HAV (i.e., no seroprevalence data; n=9), no seroprevalence data (n=17), and other viral hepatitis (n=16; Figure 1)”. All reasons for exclusion were detailed in Figure 1 (page 18).  
• In the studies reported adjusted odds-ratios derived from logistic regression, the adjusted factors varied across studies. We have included in Table 2 the risk profiles for these study populations (i.e., Population, location and survey year) in order to facilitate the interpretation of the adjusted odds-ratios. In the Methods section on page 6, we described the reporting of risk profiles together with adjusted odds-ratios as follows: “If available, adjusted odds ratios (AOR) for seropositivity of both demographics and risk factors were extracted, together with the baseline risk of HAV seropositivity (i.e., population, location and timing of the survey)”.
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<th>Reviewer #2</th>
<th>“Seroprevalence (%)”.</th>
<th>• Could you differentiate more clearly within ‘subjects born outside Canada’ between born in industrialized nations (e.g., Northern Europe) versus in developing countries?</th>
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<tr>
<td>Dr. Robert Steffen</td>
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<td>• Suggest you add a few details about the age structure in the Inuit population described on page 9, paragraph 3.</td>
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<td>• You may also consider to mention that analysis of lifetime exposure to HAV in the Canadian population might be worthwhile to be analyzed.</td>
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<td>• Thank you! We have re-labeled the x-axis of Figure 2 accordingly (page 19).</td>
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<td>• Thank-you for your suggested revisions; they helped improve our manuscript.</td>
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<td>• Thank-you very much for all of your help with our manuscript. There was variation in the definitions of “subjects born outside Canada”. We discussed this issue in the first paragraph of the Discussion section in the previous version of our manuscript: “Reporting of data was inconsistent with respect to age stratification and definition of risk factors.” The idiosyncratic way studies reporting birth-place data related “subjects born outside Canada” was described in Table 3 (page 22).</td>
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<td>• We have added the typical age structure of an Inuit community of 850 for which a survey was conducted on 720 inhabitants (Minuk et al., 1982). This was described as follows on page 8-9: “For example, Minuk and colleagues reported on a seroprevalence survey of 720 inhabitants of an Inuit community (n=850). Approximately 27% of this community were aged 0-9, 30% aged 10-19, 32% aged 20-49, and 11% aged 50 or above.”</td>
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<td>• The prevalence of HAV antibody denotes the lifetime risk of HAV infection (i.e., once antibody develops, further infection is not possible).</td>
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<td>• Thank-you for all of your suggestions; they helped improve our manuscript.</td>
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