PEER REVIEW HISTORY

BMJ Open publishes all reviews undertaken for accepted manuscripts. Reviewers are asked to complete a checklist review form (see an example) and are provided with free text boxes to elaborate on their assessment. These free text comments are reproduced below. Some articles will have been accepted based in part or entirely on reviews undertaken for other BMJ Group journals. These will be reproduced where possible.

ARTICLE DETAILS

TITLE (PROVISIONAL)	Patients' subjective assessment of the duration of cataract surgery: A case series
AUTHORS	Rothschild, Pierre-Raphaël; Grabar, Sophie; Le Du, Brivael; Temstet, Cyril; Rostaqui, Olga; Brezin, Antoine

VERSION 1 - REVIEW

REVIEWER	Roxana Ursea, MD Assistant Professor of Ophthalmology Director, Cornea and Refractive Surgery Division Department of Ophthalmology, University of Arizona
REVIEW RETURNED	02-Jan-2013

GENERAL COMMENTS	The authors are addressing an important fissue from the patient's perspective, not as much for the surgeon's perspective, in accessing the duration of cataracts surgical procedure. The study is worth publishing after major revisions. The points that need to be addressed are the following: 1. The pain was grossly estimated. We would recommend an objective pain scale to be used by the patients. There was no consideration of the different pain thresholds that patients might have. 2. The conscious sedation delivered does influence the patient's perception. The hydroxyzine or other medications given could influence the accurate estimation of sensation, pain, and duration. 3. There was no mention if non-steroidal anti-inflammatory drugs were started pre-operatively. 4. There was no mention if the patient included in the study had any prior surgery, if they were using any painkillers for other medical problems, or if they were on any anti-anxiety drugs. 5. The authors should comment on the patients who had both eyes done, and compare the perception they had during the first eye surgery compared with the second eye surgery. The cohort included contains too many variables, including the various types of anesthesia given, the numbers of surgeons involved, and the different surgical experiences of the surgeons. They mention that some parts of the surgery were performed by residents in certain cases. Those patients should be excluded from the study. Better organization and structure of the results are recommended to clearly delineate the variables.

REVIEWER	Dr Rengaraj Venkatesh, MD Chief Medical Officer, Aravind Eye Hospital and Post Graduate Institute of Ophthalmology,

	Pondicherry-605007, India
REVIEW RETURNED	09-Feb-2013

THE STUDY	Exclusion criteria not defined well. Sample size estimation not mentioned at all.
RESULTS & CONCLUSIONS	Over estimation of sample size interfering with the p value of the correlation coefficient "r"
REPORTING & ETHICS	Ethics and IRB clearance, patient consent issues not mentioned in the Methods section
GENERAL COMMENTS	1. Methods section says that any adverse event that prolonged the procedure by 10 min or more was excluded. It is unclear how this cut off period was chosen. 2. The median time for the surgery is more than 10 min in the results. What was the cut off period when patients were excluded from the study? Please explain exclusion criteria. 3. Were subjects with poor mydriasis included? Pupillary diameter can considerably influence surgical times. Was this measured? 4. The authors have not mentioned anything regarding sample size calculation. The p value obtained with the correlation coefficient "r" depends a great deal on the sample size. Too large a sample may lead to significant p value even for a small "r" value.

% discordance	**If N=50**	**If N=100**	**If N=150**	**If N=200**	**I**
	-------Below is 95% Confidence Intervals centered around disc				
10%	2-18%	4-16%	5-15%	6-14%	
20%	9-31%	12-28%	14-26%	15-25%	
30%	17-43%	21-39%	23-37%	24-36%	
40%	26-53%	30-49%	32-48%	33-47%	
50%	31-64%	40-60%	42-58%	43-57%	

Consider that the above table shows % discordance levels between subjective and Objective surgical durations (first column). The actual discordance rate from the study is 10% (100 – Concordance rate of 90% from the study). As you can see, any sample more than 200 does not add to the strength of the study for a discordance rate ranging from 10-50%. However, too large a sample does affect the p value of the correlation coefficient "r". In my opinion, the sample

size is too large to answer the study question.

5. Pearson's correlation coefficient and ICC show only a moderate correlation between objective and patient assessed duration.
6. The authors must use multivariate linear regression models (outcome variables are continuous) along with ANCOVA. Univariate and multi-variable analysis must include Regression coefficients. In table 2, the SS (sum of squares) and MS (Mean squares) values are identical for continuous variables as the degree of freedom is 1 for these. This does not allow easy interpretation of facts, neither do the SS and MS values. A Regression coefficient allows superior interpretation as it displays change in dependent variable with unit change in independent variable. E.g: Change in objective surgery duration (in minutes) per unit change in vision (0.1logMAR), fasting time (1min) etc. 95%CI for these regression coefficients should also be included along with the already reported p values
7. In the Bland-Altman plot, the solid and dash line should be labeled within the plot as well and a 68% confidence interval on either side should also be shown and labeled.
8. The correlation between objective and subjective surgical duration is only fair **and not strong** (r value less than 0.5). The p value reported with this is also questionable due to over sampling (see point 3). Hence, preoperative information regarding the objective surgical time may or may not influence patient anxiety and comfort. The data generated by this study will be meaningful only if it demonstrates a change in patient comfort scores. This must be discussed in a better manner by the authors.
9. From the current study, it may be appropriate to inform the patient that he/she may experience a longer duration of surgery as he/she is old (older than median age in the study), especially if a less experienced surgeon is operating on him/her and he/she experiences considerable intraoperative pain. As one can see, this information is not desirable in preoperative counseling unless measures to improve patient comfort are also demonstrable. Neither does this information surprising.
10. A 90% concordance rate between objective and subjective surgical duration is very impressive but cannot be used as a surrogate for patient comfort levels
11. In Line 235 in the discussion section the authors say that their median objective surgical time is better than many elite surgeons despite 30% of the study surgeons being junirs/residents. Howeverresidents the time for residents/juniors is significantly higher than seniors. Hence this line should be omitted.

VERSION 1 – AUTHOR RESPONSE

Reviewer: Roxana Ursea, MD
Assistant Professor of Ophthalmology
Director, Cornea and Refractive Surgery Division
Department of Ophthalmology, University of Arizona
655 North Alvernon Way, Suite 108
Tucson AZ 85711-1824

The authors are addressing an important issue from the patient's perspective, not as much for the surgeon's perspective, in accessing the duration of cataracts surgical procedure. The study is worth publishing after major revisions. The points that need to be addressed are the following:

1. The pain was grossly estimated. We would recommend an objective pain scale to be used by the patients. There was no consideration of the different pain thresholds that patients might have.
Our study was focused on the perception of time. The perception of pain was a secondary outcome measure, which we assessed to evaluate its correlation with our main outcome measure.
In studies focused on the perception of pain, questions were usually asked in the recovery room, about half-an-hour after the end of the procedure, or even later. However, because our study was focused on the perception of time, our questions to the patients were asked immediately at the end of the procedure, while drapes were removed. At that time, the operated eye had not yet recovered a functional vision and ocular discomfort may have impeded the use of a standard 10-point visual analogue scale. Hence, we used the simplest validated scale focused on pain assessment, with 5 categories (no sensation, mild sensation, moderate pain, severe pain, unbearable pain), which could be quickly and easily evaluated. This simplified verbal 5-point pain scale has been already used and validated in other studies referenced in our manuscript: [Roman et al. Topical versus peribulbar anesthesia in cataract surgery. J Cataract Refract Surg 1996;22:1121-4. and Vielpeau et al. Comparative study between topical anesthesia and sub-Tenon's capsule anesthesia for cataract surgery. J Fr Ophtalmol 1999;22:48-51.] Moreover, the study by Vielpeau et al. was recently included in a Cochrane review, also included as reference in our manuscript: [Davison et al. Sub-Tenon's anaesthesia versus topical anaesthesia for cataract surgery. Cochrane Database Syst Rev 2007(3):CD006291e.]
The assessment of the different pain thresholds of patients is a complex task. Such an assessment has been made in other studies using validated anxiety scales such as the APAIS (Amsterdam Preoperative Anxiety and Information Scale) or the STAI (State-Trait Anxiety Scale). The assessment of pain thresholds was not within the scope of our study. Moreover, as all our patients received hydroxyzine preoperatively, we assumed that this could have hindered analyses focused on pain thresholds.
The following sentence has been added to the discussion section of our revised manuscript.
[Line 266-270: This discrepancy could be due to the preoperative sedation given to all our patients. Such medications can alter the perception of pain as well as the perception of duration and also aim at reducing anxiety. Similarly, we did not account for the patients' systemic medications or illnesses, if any, which could also have altered their judgment and their pain thresholds.]

2. The conscious sedation delivered does influence the patient's perception. The hydroxyzine or other medications given could influence the accurate estimation of sensation, pain, and duration.
We agree that hydroxyzine could have altered our patients' perception of pain. Given that all our study patients were on this medication, we could not adjust or take into account this variable as a potential confounding factor.
We have further discussed this issue in our revised manuscript.
[Line 266-270: This discrepancy could be due to the preoperative sedation given to all our patients.

Such medications can alter the perception of pain as well as the perception of duration and also aim at reducing anxiety. Similarly, we did not account for the patients' systemic medications or illnesses, if any, which could also have altered their judgment and their pain thresholds.]
]

3. There was no mention if non-steroidal anti-inflammatory drugs were started pre-operatively.
Non-steroidal anti-inflammatory drugs were not used in our study.
The following sentence has been added to the methods section:
[Line 142-143: No other drug was given preoperatively, including non-steroidal anti-inflammatory drugs]

4. There was no mention if the patient included in the study had any prior surgery, if they were using any painkillers for other medical problems, or if they were on any anti-anxiety drugs.
The data regarding prior ocular surgery was not assessed. We believe that the great majority of our patients had cataract surgery in eyes not operated previously. Our procedures do not differ in patients with a history of other ocular surgery, such as vitrectomy or glaucoma surgery.
As pain was not the main outcome measure in our study, we did not record the use of painkillers, nor medical problems or anti-anxiety drugs. However, given that our patients fasted from midnight before the day of their surgery and that the half-life of most painkillers is short, a washout effect must have occurred at the time of the procedure.
These limitations are discussed in the revised manuscript: [Line 266-270 This discrepancy could be due to the preoperative sedation given to all our patients. Such medications can alter the perception of pain as well as the perception of duration and also aim at reducing anxiety. Similarly, we did not account for the patients' systemic medications or illnesses, if any, which could also have altered their judgment and their pain thresholds.]

5. The authors should comment on the patients who had both eyes done, and compare the perception they had during the first eye surgery compared with the second eye surgery.

The following sentences have been added to the revised manuscript:
Results section: [Line 183-187: The perception of pain did not significantly differ between first and second eye procedures. Out of 155 patients operated in their first eye 113 patients (73%), reported low pain [no or mild sensation (score 0 or 1)], while 92 of 128 patients (72%) operated on their second eye rated their sensations similarly (p=0.9).] and [Line 219-220: Conversely, patient-assessed duration did not significantly differ between first and second eye procedures or according to gender.)]
Discussion section [Line 261-266 In a previous study patients tended to report their second eye surgery as more painful than their first eye surgery and this finding was related to a decreased preoperative anxiety at the time of the second procedure.[16] However, this finding was not observed in our study, nor in another recent report.[18] This discrepancy could be due to the preoperative sedation given to all our patients. Such medications can alter the perception of pain as well as the perception of duration and also aim at reducing anxiety.]

The cohort included contains too many variables, including the various types of anaesthesia given, the numbers of surgeons involved, and the different surgical experiences of the surgeons. They mention that some parts of the surgery were performed by residents in certain cases. Those patients should be excluded from the study. Better organization and structure of the results are recommended to clearly delineate the variables.
As suggested, we removed from our analyses cases in which residents participated in the procedure. We also removed the patients for whom additional anaesthesia or sedation was administered.
As suggested, we also removed variables that were analyzed in our previous version of the manuscript, such as phacoemulsifier type.
These modifications are described in the methods section of the revised manuscript [Line 118-122:

Similarly, patients who required any anaesthesia in addition to topical lidocaine 2% gel, or those who required sedation in addition to the preoperatively given hydroxyzine were excluded from the analyses. Teaching cases involving resident participation were excluded from the analyses].

¬ Reviewer: Dr Rengaraj Venkatesh, MD
Chief Medical Officer,
Aravind Eye Hospital and Post Graduate Institute of Ophthalmology, Pondicherry-605007, India

Ethics and IRB clearance, patient consent issues not mentioned in the Methods section

This study did not imply the testing of any new therapeutic method nor did it require any change in our standard of care. As such, the study did not require prior approval by an ethics committee or an IRB under the French legislation. Following this reviewer's comment, we have formally questioned our IRB on this matter. We have received confirmation that our study did not require prior IRB approval, nor the signing of informed consents other than those that we routinely use for all patients undergoing cataract surgery. We are attaching our IRB's response letter regarding this matter.

1. Methods section says that any adverse event that prolonged the procedure by 10 min or more was excluded. It is unclear how this cut off period was chosen.

The focus of our study was on standard cataract surgery. Events significantly affecting the duration of the procedure may have resulted either from surgical complications (e.g. vitreous loss), or from technical glitches (e.g. phacoemulsifier malfunction).

Any cut off point is somehow arbitrary. We decided on 10 minutes added to the procedure as our cut-off, as this length of time could have doubled the duration of some cases.

In the revised manuscript we more clearly defined an "uneventful procedure" as a procedure without any "significant intraoperative adverse event". A "significant intraoperative adverse event" is also further defined in the methods section of the revised manuscript [Line 114-121: All patients who had uneventful phacoemulsification under topical anaesthesia with placement of an intraocular lens in the capsular bag were included. Cases with any "significant adverse event" defined either by a major intraoperative complication such as vitreous loss or by a technical problem such as phacoemulsifier malfunction that prolonged the procedure by 10 minutes or more were excluded. Similarly, patients who required any anaesthesia in addition to topical lidocaine 2% gel, or those who required sedation in addition to the preoperatively given hydroxyzine were excluded from the analyses.]

2. The median time for the surgery is more than 10 min in the results. What was the cut off period when patients were excluded from the study? Please explain exclusion criteria.

There is a subtle point here. As stated above, if a surgical complication occurred or if a technical problem lasting more than 10 minutes arose, these cases were excluded. However, long procedures that were not due to the above were kept in our analyses. These long procedures might have been performed by junior surgeons (although the cases involving residents have been excluded from our revised manuscript) and/or involved particularly hard lenses. Moreover, as stated below, poor pupil dilation might have played a role, although this was not within the scope of parameters recorded for the purpose of our study.

3. Were subjects with poor mydriasis included? Pupillary diameter can considerably influence surgical times. Was this measured?

Indeed, poor pupil dilation may have influenced the duration of some cases. This was not recorded in our study and we are unable to assess correlations between the pupil size and the duration of surgery in our series. Our surgical cases are not systematically video recorded and we are therefore unable to retrieve this information by now. As pupil size can vary during the procedure, it is difficult to assess this parameter. In our opinion, the recording of its influence on the duration of surgery would require a specific study. This limitation is discussed in the revised manuscript

[Line 269-270: Preoperative standardized grading of cataracts or pupil size were not recorded in our study]

4. The authors have not mentioned anything regarding sample size calculation. The p value obtained with the correlation coefficient “r” depends a great deal on the sample size. Too large a sample may lead to significant p value even for a small “r” value. Consider that the above table shows % discordance levels between subjective and Objective surgical durations (first column). The actual discordance rate from the study is 10% (100 – Concordance rate of 90% from the study). As you can see, any sample more than 200 does not add to the strength of the study for a discordance rate ranging from 10-50%. However, too large a sample does affect the p value of the correlation coefficient “r”. In my opinion, the sample size is too large to answer the study question.
We agree that the larger the sample, the lower the p-value for a given effect size. Our large sample requires a cautious interpretation of the results even if the p-values are low.
However, we have excluded all the cases involving resident participation in our revised manuscript, as recommended by the other reviewer . This substantial decrease in sample size from 359 cases to 283 cases attenuates the oversampling issue.
All these relevant aspects have been added in the discussion section of the revised manuscript.
[Line 280-283 Most patients quite correctly assessed the duration of their surgery, though the correlation with objective surgery duration was only moderate and samples were large. Hence, we were not able to identify specific characteristics significantly associated with an underestimation or an overestimation of time.]
5. Pearson's correlation coefficient and ICC show only a moderate correlation between objective and patient assessed duration.
We agree that the correlation between objective and patient-assessed duration found with the ICC or Pearson's correlation coefficient is only moderate. We have changed the term “fair” to “moderate” throughout the text when referring to the correlations related to the ICC or Pearson's correlation:
[Line 194-196 Intraclass correlation coefficient was 0.341 (95% CI, 0.23-0.44) suggesting moderate agreement between the objective and patient-assessed duration.]
6. The authors must use multivariate linear regression models (outcome variables are continuous) along with ANCOVA. Univariate and multi-variable analysis must include Regression coefficients. In table 2, the SS (sum of squares) and MS (Mean squares) values are identical for continuous variables as the degree of freedom is 1 for these. This does not allow easy interpretation of facts; neither do the SS and MS values. A Regression coefficient allows superior interpretation as it displays change in dependent variable with unit change in independent variable. E.g: Change in objective surgery duration (in minutes) per unit change in vision (0.1logMAR), fasting time (1min) etc.95% CI for these regression coefficients should also be included along with the already reported p values
To improve clarity and facilitate the interpretation of the results, univariate and multivariate linear regression models along with ANCOVA have replaced the previous analyses in table 2 and table 3. Regression coefficients, 95% CI for these regression coefficients and p values are now all reported within the tables.

7. In the Bland-Altman plot, the solid and dash line should be labelled within the plot as well and a 68% confidence interval on either side should also be shown and labelled.
The solid (bias) and dash line (95% CI) have been labelled within the plot as suggested and the 68% confidence interval has been added and labelled either.

8. The correlation between objective and subjective surgical duration is only fair and not strong (r value less than 0.5). The p value reported with this is also questionable due to over sampling (see point 3). Hence, preoperative information regarding the objective surgical time may or may not influence patient anxiety and comfort. The data generated by this study will be meaningful only if it demonstrates a change in patient comfort scores. This must be discussed in a better manner by the authors.
As discussed in item 5, we agree that the correlations are moderate and not strong. This is now clearly stated in the revised manuscript [Line 274-276: Surprisingly, the age of the patient was not correlated with objective surgery duration but with patient-assessed surgery duration, though weakly.]

Similarly, as discussed in item 3, we agree on the cautious interpretation of the p-value given the large sample size. This issue has been partially addressed by the substantial decrease in our sample size. These limitations are now discussed in the revised manuscript
[Line 279-280: [Most patients quite correctly assessed the duration of their surgery, though the correlation with objective surgery duration was only moderate and samples were large]
As underlined by the reviewer, the clinical relevance of our findings need further studies addressing the impact of preoperative information on patient comfort, as it has been conducted regarding other intraoperative sensations. This aspect has been more thoroughly dealt with in the revised manuscript:
Abstract: [Line 78-80: However, the benefit of preoperative counselling regarding the duration of surgery will need further evaluation.]
Introduction section: [Line 99-102: Providing additional targeted information to patients undergoing cataract surgery has been shown to improve their satisfaction.[8] This information could include data regarding the duration of the procedure.]
Discussion section of the revised manuscript. [Line 300-302:. However, proving the benefit of preoperative counselling in terms of patient satisfaction would require a specific study beyond the scope of this report.]
9. From the current study, it may be appropriate to inform the patient that he/she may experience a longer duration of surgery as he/she is old (older than median age in the study), especially if a less experienced surgeon is operating on him/her and he/she experiences considerable intraoperative pain. As one can see, this information is not desirable in preoperative counselling unless measures to improve patient comfort are also demonstrable. Neither does this information surprising.
The most striking finding of our study was that patients fairly estimated the duration of their surgery, whatever the circumstances. This had not been ascertained previously and we were unable to find any existing literature on the topic. We expected some large discrepancies and were willing to assess what variables could lead to an over- or an underestimation. Those variables could have been the target of corrective measures likely to improve patient comfort. The benefit of providing this information to patients would need another specific study (see item 8 above), as now acknowledged in the revised manuscript: [Line 300-302 However, proving the benefit of preoperative counselling in terms of patient satisfaction would require a specific study beyond the scope of this report.]

10. A 90% concordance rate between objective and subjective surgical duration is very impressive but cannot be used as a surrogate for patient comfort levels
Our study was not targeted at assessing the benefit of patient counselling. Other published studies already provide data showing that preoperative information is worthwhile.
The following sentence has been added to our revised manuscript [Line 300-302 However, proving the benefit of preoperative counselling in terms of patient satisfaction would require a specific study beyond the scope of this report..]
11. In Line 235 in the discussion section the authors say that their median objective surgical time is better than many elite surgeons despite 30% of the study surgeons being juniors/residents. However the time for residents/juniors is significantly higher than seniors. Hence this line should be omitted.
As suggested, this line has been removed from the revised manuscript

VERSION 2 – REVIEW

REVIEWER	Dr Rengaraj Venkatesh Chief Medical Officer, Aravind Eye Hospital, Thavalakuppam, Pondicherry-605007, India I have no competing interests in the content of the manuscript and harbor no association with the authors
REVIEW RETURNED	27-Mar-2013

REPORTING & ETHICS	Clearance from the institutional review board must be mentioned in the beginning of the methods section
GENERAL COMMENTS	The manuscript has been revised well and is eloquently written. I only have only a few comments. 1. In terms of the cases excluded from the analysis i.e. 85 cases, the authors report that 9 were excluded for intra-op complications, 13 for additional anesthesia and 70 for residents participation. This adds up to 92 cases excluded but the authors mention that 85 cases were excluded. Kindly sort out this discrepancy 2. In the abstract, the word fairly should be replaced by the word “moderately” in an appropriate manner 3. I would prefer that the methods section begin with the setting followed by a statement saying that the study was approved by the institutional review board. This has not been mentioned previously in the manuscript 4. The footer at bottom of table 2 must be deleted as one uses liner regression analysis for univariate analysis because the outcome measure is a continuous variable (i.e. time). The student t test is not used for categorical variables at all. 5. One may create separate tables for Objective and Patient assessed surgical times displaying univariate and multivariable analysis in the same table i.e. Table 2 may show univariate and Multivariable linear regression analysis results for Objective surgery duration and table 3 may show univariate and Multivariable linear regression analysis results for subjective surgery duration. However, this is not a compulsion but just a suggestion. The authors may choose to leave the tables as they are.

VERSION 2 – AUTHOR RESPONSE

Replies to the reviewer’s comments :

1. In terms of the cases excluded from the analysis i.e. 85 cases, the authors report that 9 were excluded for intra-op complications, 13 for additional anesthesia and 70 for residents participation. This adds up to 92 cases excluded but the authors mention that 85 cases were excluded. Kindly sort out this discrepancy

This discrepancy stems from the fact that some cases were excluded for several motives, e.g, a resident-performed case with intraoperative capsular rupture requiring additional anesthesia. To clarify this point, we have modified the first paragraph of the results section as follows :

Line 171-180 of the revised manuscript (unmarked copy): "A total of 283 cases performed in 218 patients were analyzed after exclusion of 85 cases (65 patients) which met one or more exclusion criteria as detailed herein. Resident participation was the most frequent motive for exclusion (70 cases). Other causes were significant intraoperative adverse events including posterior capsular break or zonular disinsertion (8 cases) and phacoemulsifier breakdown (1 case). Four out the 8 cases presenting intraoperative vitreous loss had an identifiable risk factor for this complication: two were traumatic cataracts and two were cataracts related to severe pseudoexfoliation syndrome. Thirteen cases required additional anaesthesia or sedation including sub-Tenon’s block (5 cases), sub-conjunctival injection (1 case), intracameral injection of lidocaine (1 case) and/or midazolam intravenous sedation (6 cases)."

2. In the abstract, the word fairly should be replaced by the word “moderately” in an appropriate manner

The words fair and fairly have been removed from the abstract’s revised version.

Line 66-67 of the revised manuscript (unmarked copy): “Furthermore, Bland-Altman analysis and the intraclass correlation coefficient (0.341, 95% CI, 0.23-0.44) were quite in agreement”.

Line 75-79 of the revised manuscript (unmarked copy): " In our study, patients' estimated and real duration of the surgery showed moderate agreement, suggesting that emotions associated with eye surgery under topical anaesthesia did not dramatically hinder patients' perception of time. However, the benefit of preoperative counselling regarding the duration of surgery will need further evaluation "
The abstract is now 299 words long.

3. I would prefer that the methods section begin with the setting followed by a statement saying that the study was approved by the institutional review board. This has not been mentioned previously in the manuscript
We have added the following sentence as recommended:
Line 111-114 of the revised manuscript (unmarked copy): "The study was set in the department of ophthalmology of Hôpital Cochin, a teaching university hospital located in Paris, France. Data were collected prospectively in consecutive patients operated between May 17, 2011 and July 22, 2011 and was approved by the Institutional Review Board."

4. The footer at bottom of table 2 must be deleted as one uses liner regression analysis for univariate analysis because the outcome measure is a continuous variable (i.e. time). The student t test is not used for categorical variables at all.
Correlation tests were performed with linear regression, while Student's t-test was used to compare means.
To clarify the use of each of these two tests the footnote of table 2 has been modified as follows :
" * Linear regression for correlation tests and Student's t-test for mean comparison."

5. One may create separate tables for Objective and Patient assessed surgical times displaying univariate and multivariable analysis in the same table i.e. Table 2 may show univariate and Multivariable linear regression analysis results for Objective surgery duration and table 3 may show univariate and Multivariable linear regression analysis results for subjective surgery duration. However, this is not a compulsion but just a suggestion. The authors may choose to leave the tables as they are.
As suggested, we considered presenting these data in a single table, but we preferred to distinguish results from univariate and multivariate analyses.