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Title	**Factors affecting management of children's low risk distal radius fractures in the emergency department: a population-based retrospective cohort study**
Authors	Tara Baxter MD MSc, Teresa To PhD, Maria Chiu PhD, Mark Camp MD, Andrew Howard MD MSc
Reviewer 1	Andrew Dixon
Institution	University of Alberta, Pediatrics
General comments	Comments to the Author Overall, the paper is well written and summarizes the results of the study well. However, I do have on major reservation about the study. You have defined LRPDRF as any forearm fracture that did not require reduction (in the ED or OR). This seems a very broad category to determine that appropriate management is a splint with no follow up. What about fractures on the edge of needing a reduction that need monitoring? While I agree that there is good evidence for buckle fractures, it is less clear that all eventually non-operative forearm fractures should be managed without followup. There is one study in the references on this subject by one of the authors of this study, but I do not think this is clearly accepted practice in the PEM or Ortho communities. Therefore, it is not appropriate to determine the practice of the physicians in Ontario is inappropriate from the data presented. Without a clearer understanding of what the nature of these fractures was-I do not think it is possible to determine if the management was appropriate. Is it possible to separate out the buckle fractures? Perhaps there is some information that was not clearly conveyed? If so, please clarify your reasoning behind the study design. Other comments P10 Line 24 the references given only discuss cast saw injuries -not cost or over treatment P11 Line 23 I am curious why patients under 2 were excluded P 15 Line 41 Is the abscence of follow up from rural sites really part of a larger problem. Does it mean that nobody gets follow-up even if they do need it? Without a baseline for other fractures it isn't easy to tell. Conclusion I think at this point the conclusions need to remain that there may be an issue with over treatment, but as pointed out on P17 Line 50 without an analysis of the subtypes of LRPDRF it is not possible to clearly comment on the adequacy of treatment.
Reviewer 2	Ken Farion,
Institution	University of Ottawa, Departments of Pediatrics and Emergency Medicine
General comments	Comments to the Author Thank you for this well written paper that is clear and concise. My questions/suggestions are confined to the following three minor items: 1) Primary Outcome - can you clarify what would happen to a patient seen at a peripheral ED and referred to a PED for management? If the PEM MD recognized the LRPDRF and appropriately managed with removable splinting and no specific

	follow-up, where would this case fall in the cohort? 2) Figure 2 - please check the ICD-10A diagnoses codes for these relevant fractures - I think you're missing decimal points (S52500 s/b S52.500, etc.) 3) While you mention it briefly regarding the potential loss of income to orthopedic surgeons if these follow-ups were eliminated, I do feel there should be significantly more discussion about this issue. One of the strongest mechanisms for the change to a more simplified algorithm would be feedback from the orthopedic surgeons to the physicians continuing to make unnecessary referrals. Without this feedback loop, it is hard to envision how those who are not aware of the practice or haven't adopted it out of their conservative nature or family pressure would ever change.
Author response	We have reframed the paper as requested and revised the paper according to the reviewer comments.