Table 2
Bivariate and multivariate comparisons among parental insurance coverage and willingness to take PrEP stratified by participant characteristics.

Characteristics	Parental Insurance Coverage		Willingness to Take PrEP			
	Unadjusted OR	95% CI	Unadjusted OR	95% CI	Adjusted OR	95% CI
Parental insurance coverage	–	–	0.52	0.25–1.07	0.43	0.15–1.98
Age						
– 18–20	5.69**	2.74–11.82	1.11	0.53–2.37	–	–
– 21–25	0.32**	0.15–0.68	0.93	0.42–2.05	0.94	0.33–2.71
Race						
– White	1.14	0.28–4.59	0.53	0.11–2.63	–	–
– Undefined	1.09	0.28–4.32	3.15	0.61–16.29	3.08	0.54–17.61
– Black	0.58	0.22–1.55	2.34	0.63–8.75	1.36	0.33–5.58
Previous HIV test	0.68	0.30–1.51	4.34**	1.24–15.15	4.65	0.54–39.6
History of STI	0.46*	0.21–1.00	2.00	0.92–4.34	2.55	0.94–6.92
Do not want parents to know that they're taking PrEP	1.26	0.65–2.45	0.32**	0.15–0.66	0.30**	0.11–0.85
Unlikely to use PrEP if…						
– Needed to talk to parents about side effects of PrEP	1.00	0.46–2.17	0.44**	0.20–0.98	0.62	0.12–1.3.21
– Needed to talk about the sex they're having	1.69	0.67–4.25	0.45	0.18–1.11	1.42	0.25–8.01

* Indicate variable significantly associated at p-value = 0.05.
** Indicate variable significantly associated at p-value < 0.05.

Declarations of interest

None.

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Comments on Shenfu injection for improving cellular immunity and clinical outcome in patients with sepsis or septic shock

To the Editor,

We read with interest the article by Ning Zhang et al. [1]. The author conducted a prospective, random, controlled trials (RCTs) to compare the clinical effects and safety of Shenfu injection (SFI) in patients with sepsis or septic shock, which found that SFI should improve cellular immunity but not clinical outcome. We congratulate the authors for this successful article, however, some issues should be discussed to avoid misinterpretations.

The authors claimed their Sepsis and Septic Shock diagnostic criteria in this RCTs based on the Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3) [2], however, the international

Abbreviations: SFI, Shenfu injection; RCTs, random, controlled trials.

guideline of Sepsis-3 on this journal came out until February 22, 2016, so how could this RCT carry out June 2010 to November 2012 when this guideline had not been available? We thought the diagnostic criteria should be based on the guideline of Sepsis-2, which came out on 2003 [3].

The calculation of sample size for this RCTs should be based on the primary outcomes, however, the author in the statistical analysis part of article presented that the sample size was calculated based on mortality at 28 days, which was the secondary outcome in the clinical outcomes part. To detect an absolute 20% difference in mortality at 28 days between the SFI and placebo group (40% mortality) with an 80% power at a 2-sided P value of 0.05, 79 patients without loss of follow-up needed for each group by the section of tests for two independent proportions in NCSS-PASS V.15.05 (NCSS, LLC, Utah, USA) [4]. In view of the lowest 10% rate of loss of follow-up, another 8 patients needed for each group, hence, 166 patients needed not 160.

SFI is a light yellow or light brown liquid while placebo (0.9% saline) is colorless and transparent, however, the author did not explain clearly how patients and investigators remained blinded to the treatment, which was so important for it could result in intraobserver bias in clinical outcomes (e.g. length of ICU stay, duration of vasopressor use) that leaded to a not so reliable result.

According to Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock: 2016 [5], norepinephrine should be the initial vasopressors of choice, vasopressin and epinephrine could add to norepinephrine, dopamine should be the first alternative agent in in highly selected patients (e.g., patients with low risk of tachyarrhythmias and absolute or relative bradycardia), dobutamine should be used in patients with persistent hypoperfusion despite adequate fluid resuscitation and vasopressor use. Hence, the types and doses of vasopressor should be provided and compared not just the duration of vasopressor use.

Finally, we appreciate Zhang et al. for their meaningful study, though some minor issues should be discussed and improved.

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Ethical approval and consent to participate

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Consent for publication

Not applicable.

Availability of supporting data

Not applicable.

Conflicts of interest

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Perceived impact of physician-in-triage on resident education

Emergency department (ED) overcrowding is a problem that has deleterious consequences for both patients and providers. Complications from such a burden on the ED include prolonged wait times, patient dissatisfaction, decreased productivity, and increased patient mortality [1,2]. The physician-in-triage (PIT) model has become increasingly popular in ED settings with results suggestive of a positive impact on ED throughput [3-6]. Our ED implemented a novel PIT, termed the Rapid Assessment Team (RAT), exclusively for patients arriving via emergency medical services (EMS). The objective of this study is to explore the impact of our

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