Dear reviewers,

Thank You for your comments.

Regarding haemophilia therapy during surgery: Traditionally, immediately preoperatively in the absence of FVIII inhibitory antibodies (i.e. confirmed normal recovery and half life of FVIII), either recombinant or plasma-derived FVIII is infused intravenously to secure haemostasis by reaching normal FVIII levels (usually 80-100%). In contrast, the presence of inhibitors neutralise FVIII, and for the surgery FVIII bypassing agents, either activated prothrombin complex concentrate (aPCC, FeibaR) or recombinant activated Factor VII (rFVIIa, NovoSeven), are the current effective options to maintain surgical haemostasis of blood. The specific agent is chosen according to the individual bleeding phenotype, history and patient weight.

In one case, a unicondylar knee replacement was performed to a patient devoid of previous inhibitor history. The patient suffered from posttraumatic medial arthrosis and the primary hemostatic outcome was good. However, a rapid revision (9 months postoperatively) was performed because of aseptic loosening of components. The loosening was thought to result from mechanical factors, but the compromised haemostasis by haemophilia may also play a role. In our experience, we do not recommend unicondylar knee arthroplasty to a patient with haemophilia.

Also, the tables are simplified for more explicit appearance.

Yours sincerely,

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