COMMENTS TO AUTHORS

Venous thrombosis, including deep vein thrombosis and pulmonary embolism, is associated with well recognized exogenous and endogenous risk factors. Cancer patients have an increased risk of thrombosis due to a combination of factors including type of cancer, tumor size, surgery, presence of distant metastases, chemotherapy or hormonal therapies. Some studies indicated that venous thrombosis is associated with hyperglycaemia. However, diabetes or glucose metabolism are not presented as strong pro-thrombotic factors in epidemiological study. The authors investigated the effects of glycemic parameters on venous thromboembolism risk in various gastrointestinal cancer. They concluded that the evaluation of glucose metabolic asset may allow for VTE risk stratification in GI cancer. The article is interesting, methods of the study are presented concisely and there are no objections about it.

The study deals with an important problem of treatment strategy in the large group of cancer patients, though the small number of subjects tends to show preliminary character of the study and does not allow to draw population conclusions.

We thank the reviewer for the kind appraisal of our work. Text has been now revised to answer minor concerns.

Minor points

1. The investigators presented a heterogeneous group of the gastrointestinal cancer patients enrolled in the study. What was the reason to include patients with different types of cancer in the study?

   The rational for GI cancer patient inclusion was dictated by the general consensus existing on the possibility that cancer of the digestive tract (including accessory organs) could share common pathophysiological mechanisms (for both initiation and progression). In order to clarify this point we have now added the following sentence prior to the study hypothesis (page 6):

"IR, hyperglycemia and T2D are associated with several cancer types, other than breast, and accumulating evidence indicates that they could represent shared pathophysiological mechanisms for GI cancer and related co-morbidities"

2. It is surprising that the most common cause of VTE was colorectal cancer (table 12). How to explain the highest rates of VTE in these patients.
   We agree with the reviewer observation that the finding of a high VTE rate in colorectal cancer is, somehow, surprising. In our opinion, however, the individual risk of VTE in colorectal cancer patients could be boosted by active treatment, in particular by the use of bevacizumab. Indeed, in the present study VTE rates were higher in patients receiving bevacizumab (17% vs. 8%, p=0.044; page 10, 3rd paragraph), although this association was not confirmed by multivariate analyses.

3. VTE rates were higher in patients receiving bevacizumab (12 patients), but almost all patients received 5-fluorouracil and leucovorin (28 patients). Did the authors perform statistical analysis including 5-fluorouracil and leucovorin.
   As stated on page 10, third paragraph, no association was found between VTE rates and different chemotherapy regimens. Accordingly, anti-cancer drugs were not presented in the final models, although their inclusion did not substantially modify the results of multivariate analyses. This has been now acknowledged on page 11, lines 11-12.

4. In supplementary table 2 was presented 34 patients not 32, why?
   We apologize for the mistake that, as a matter of fact, occurred in Table 2 (erroneously reporting a total of 32 events). Nonetheless, the correct figure of 34 VTE was reported throughout text and figures. Table 2 has been now emended and text has been carefully checked for similar inconsistencies.