Author's response to reviews

Title: Adherence to the European Society of Cardiology (ESC) Guidelines for Chronic Heart Failure - A national survey of the Cardiologists in Pakistan

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Author’s response to reviews: see over
Response to Reviewers’ Comments

Reviewer 1:

Comment 1: 4th line: “Comorbits” should be comorbidities
Response: changed to comorbidities

Comment 2: 2nd para: scip “Of all cardiovascular diseases,” heart failure is not a disease.
Response: Changed the sentence to:
The prevalence of heart failure continues to increase despite efforts at primary and secondary prevention.

Comment 3: Last para: Preferably put forward a hypothesis included >80% patients with cardiac diseases, regardless of post graduate training.
Response: Please refer to Methods para 3: Cardiologist was defined as a physician whose practice included >80% patients with cardiac diseases, regardless of post graduate training. We have used the same definition in our previous paper by Gowani et al.[1] The reason behind this is the unregulated medical practice in the country leading to considerable heterogeneity among physicians practicing cardiology in Pakistan. Hence, this definition allowed us to capture all practitioners providing specialty cardiac care in the field, regardless of credentials.

Comment 4: The results largely depend on the definition of “cardiologist”.
Response: This is noted as one of the limitations; See Discussion last para.
Etiology of heart failure in Pakistan vs. Europe? Health care systems are quite different. Are the European Guidelines adequate for the Pakistan scenario? The evaluation process of the test cardiologists remains unclear.
Response: Discussion para 2: Most common cause of heart failure is coronary artery disease in both Europe and South Asians. However, south Asians have a greater prevalence of premature heart disease given heavy burden of diabetes and other risk factors.[2] This necessitates aggressive risk factor control in Pakistani population that is tailored to fit the population behavior and health care system of Pakistan. However, there is no validated guideline that providers can follow. Most physicians are trained via a European system and are familiar with the European guidelines. It does remain a question whether adherence to these guidelines will be adequate to improve HF mortality in Pakistan.

Comment 5: Exactly define in what respect the cardiologists were non-compliant to guidelines (drugs, doses?).
Response: Results para 4: Cardiologists made wrong choices with the type of therapy and doses of therapy.

Comment 6: How were the cases chosen? Are they representative for Pakistan or for what? Why only 3 cases?
Response: Methods Para 3:
The original questionnaire was developed by an expert panel of European Cardiologists, including two who were involved in the development and publication of the 2005 ESC guidelines. The expert panel developed three fictitious patient case scenarios that were designed to reflect different aspects of the management of patients with CHF. In summary, they were: a 69-year-old man with a history of hypertension and myocardial infarction, newly diagnosed with heart failure; a 70-year-old woman diagnosed with heart failure 2 years ago, now with exacerbation of symptoms; and a 75- year-old woman with CHF and preserved left
ventricular function. A selection of treatment options, including some that were not consistent with the 2005 ESC guidelines, was provided. This was adopted from a survey conducted by Erhardt et al among European Cardiologists with the permission of their authors.[3]

Comment 7: Discussion is wordy and in large parts redundant and can be shortened by at least 30%.
Response: Discussion has been cut down by 30%.

Reviewer 2

Comment 1: The main problem of the manuscript is that the authors evaluated the awareness and attitudes towards the ESC guidelines when only 13.8% considered ESC guidelines as relevant or very relevant for guiding treatment decisions while 92.8% of the local Cardiologists chose AHA guidelines. Probably this doesn’t introduce any serious bias in the study because the differences between the 2 guidelines are minor but it would be better to present the questionnaire they used to evaluate treatment because of the differences in acute heart failure which is not covered in the previous AHA guidelines. Moreover the questionnaire used to evaluate the barriers to implementation of guidelines should be presented.
Response: Questionnaire was attached with the manuscript. Please see appendix

Comment 2: The authors evaluated the adherence to the guidelines with 3 different clinical scenarios. The comments in the discussion about the clinical scenarios are difficult to follow. It is written that «The proportions of respondents who made recommendations that completely matched those of the guidelines were low: 7% (Scenario 1), 0% (Scenario 2) and 20% (Scenario 3)». It would be interesting to see in the appendix or in the online supplementary material of the manuscript the clinical scenarios and the questions asked. This will help the reader understand better the discussion of the manuscript.
Response: attached with the manuscript

Comment 3: A total of 372 cardiologists were approached; 305 consented to participate (overall response rate, 82.0%). How did the authors, initially, approach the cardiologists? How many reminders? Was any difference between those who answered (accepted) immediately and the others?
Response: Methods Para 2: Cardiologists were approached personally by interviewers (volunteers) in their offices. If the respondent was busy, a later time was obtained. All questionnaires were filled by respondents while interviewers present. 80% of the respondents filled the questionnaire on the first visit. There was no significant difference in awareness of guidelines between those who responded immediately and the ones on subsequent visits.

Comment 4: In the «Background», the first paragraph is not necessary. Data included in this paragraph can be found in any manuscript about heart failure. Add in this section a couple of more sentences about implementation of heart failure guidelines and how they improve outcome.
Response: 1st paragraph removed. Agree that the information can be found in reviews on heart failure. More about implementation of guidelines is in the later paragraphs in background section.

Comment 5: The discussion is too long.
Response: Discussion has been abridged by one third.

Comment 6: Correct errors/typos
