Author’s response to reviews

Title: Current European guidelines for management of arterial hypertension: Are they adequate for use in primary care? Modelling study based on the Norwegian HUNT 2 population

Authors:

Halfdan Petursson (halfdanpe@gmail.com)
Linn Getz (linngetz@med.is)
Johann A Sigurdsson (johsig@hi.is)
Irene Hetlevik (irene.hetlevik@ntnu.no)

Version: 4 Date: 29 September 2009

Author’s response to reviews: see over
Dear Editor Dr. Robin Cassady-Cain

Thank you for your e-mail dated September 11th 2009 regarding our paper

*Current European guidelines for management of arterial hypertension: Are they adequate for use in primary care? Modelling study based on the Norwegian HUNT 2 population*

We are glad to see that the reviewers are satisfied with the major changes we made in the previous revision round. We have now read the comments they made in the 3rd review round and tried to adapt our manuscript accordingly.

We start by responding to Reviewer 1 (Henry EE Stoffers, Sept 8.)

**Response to Reviewer 1**

1. (“with regard to … 3.5 follow up visits”).

We agree that it may appear inconsistent to assign more than 2 visits per year for the low risk category in question. However, the Guidelines themselves present the argument for this. In the last revision round, we added a direct quote from the guidelines as well as an explanation of how we interpret the text (p.8). We do not think it should be is necessary to revise the manuscript further at this point, but if the editor insists, we will reconsider.

Quote (manuscript p.8) ;.-*The guidelines subsequently state that “Visits should be more frequent in high or very high risk patients. This is the case also in patients under non-pharmacological treatment alone due to the variable antihypertensive response and the low compliance with this intervention”.* We defined the term “more frequent” (than to 2 visits per year) to to mean 3-4 visits per year. *Based on the above quote, we allocated an average of 3.5 visits per year for the categories ‘high added risk,’ ‘very high added risk’ and individuals with ‘low added risk’ who exhibit BP <140/90 under non-pharmacological surveillance due to the presence of other risk factors. “*

2. (“In my previous …to …has no consequences”)

We agree that there is an inconsistency between figures 1 and 2 in the Guidelines regarding Diabetes. Reviewer 1 finds figure 2 more appropriate,
whilst we have chosen to depart from figure 1. As pointed out by the reviewer, this choice does not have any consequences for our calculations. We still prefer to refer to figure 1 because it defines the risk categories and the difference in the explanatory colours.

3. I will not.. to …valuation of ‘extra’ vs. ‘regular’ work”.
This topic is also noted by reviewer 2: “how much of the workload comes in addition to what GPs currently do”. The question is highly relevant but our methods and arguments were designed to address the total workload needed to fulfil these Guidelines (see quote regarding our aims below). This is because we do not have data which would allow meaningful calculations regarding “additional” as opposed to “established” (disease-linked) workload. But since readers are likely to wonder, as the reviewers do, we did add a paragraph about this in the discussion (marked in blue in the manuscript).

Quote (manuscript p.4): “The aim of the present study was to model the implications of the most recent European guidelines for the management of arterial hypertension [13] in a general Norwegian population. We primarily estimated the prevalence of individuals with unfavourable CVD risk levels according to the guidelines. Subsequently, the potential clinical workload and workforce associated with reaching recommended treatment goals in this group were calculated”

4. „If you consider … to ...other countries”
As mentioned in our paper the average number of consultations made by GPs in Norway is 3000/year. We have not elaborated on the working tasks of Norwegian GPs and why the number of consultations is (only) 3000. This number is comparable to the Nordic countries, but it is obvious that other healthcare systems may have higher consultation rates per GP. In light of the reviewer’s comments, we did consider making (and we even drafted) examples of alternative calculations, but ended up thinking that it may be most consistent to
   - present the numbers of contacts needed in a transparent manner, and
   - model its implications with respect to the system we know and represent ourselves.

We thereby leave it open to calculate the potential impact for other systems. If the editor would indeed like us to present some hypothetical, alternative workforce calculations, we will however be glad to do that.
To accommodate the above mentioned concerns, we did adapt the text in the discussion somewhat (p.11-12, the passage marked in blue)

**Response to Reviewer 2.**
The one remaining comment from this reviewer has been addressed above, see our response to point 3

We thank you for the fruitful cooperation we have had so far and look forwards to hearing from you again soon.

With kind regards

Halfdan Petursson

On behalf of all authors