Reviewer's report

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

Version: 3 Date: 8 September 2009

Reviewer: Henri E Stoffers

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Third review of Petursson et al.

This time I will be brief in my comments. Eventually, it is the Editor who should make decisions.

I have read the reviewed paper and I have read the Letter of the authors. I agree that the paper has improved. My previous Comment 1 has been taken care of sufficiently.

With regard to my previous Comments 2 and 3 (and consequently 4) I still have unanswered questions on the apparent inconsistencies of assigning 2 or 3,5 follow-up visits to ‘low added risk’ (upper row ‘2’, but 2nd row ‘3.5’) as well as ‘moderately added risk’ (3rd row ‘3.5’, but upper row and 2nd row ‘2’): inconsistent WITHIN risk category and not logical BETWEEN risk categories. The category ‘moderately added risk’ is not discussed on p. 8. Referring to ‘lifestyle changes’ as reason to opt for 3.5 visits/yr is remarkable, because in that case everyone with life style councelling should have 3.5 follow-up visits.

In my previous Comment 3, I indeed referred to the guideline’s Figure 2, which seems the correct thing to do (to me). In that Figure (title: initiation of antihypertensive TREATMENT) the row ‘3 or more risk factors, MS, OD or diabetes’ from Figure 1 is split into two rows, making a separate row for ‘diabetes’. (For the calculations however, this has no consequences.)

I will not go into debate here on the distinction between primary and secondary prevention. The authors have a different point of view on that. However, this has consequences for the ‘valuation’ of ‘extra’ vs. ‘regular’ work.

If you consider that a year has approximately (365 days-104 weekend days-30 holidays=) 231 working days, this would yield a daily workload of 13 patients per day for a Norwegian GP. The number of GPs per 100.000 would imply 1150 patients/GP. From a Dutch perspective, both figures seem low to me. I do not know the international situation, but in the Discussion some remarks might be made on how the Norwegian situation compares to other countries?

Although the authors state that their calculations could easily be adapted to ‘alternative care models’, they do not give a quantitative indication of the possible implications. They only discus the option ‘this is not possible for the Norwegian GP in the current Norwegian health care system.'
In summary, although I cannot agree completely with the way of estimating the workload, I can understand the point the authors make: prevention is a lot of work and only the future can tell whether it has been beneficial to society as well as individual patients. However, in other countries a growth of ‘auxiliary staff’ has been made possible to perform preventive tasks better. This option is not discussed in the paper.

It is the work of politicians to use figures to illustrate their philosophy; it is the task of researchers to ask questions, produce results and discuss the (all?) possible implications.

**Level of interest:** An article of importance in its field

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

'I declare that I have no competing interests'