Author's response to reviews

Title: Predictive ability of an early diagnostic guess in patients presenting chest pain

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Author's response to reviews: see over
Dear Editor, dear reviewers,

Please find our final corrections and comments for the manuscript entitled: “Early diagnostic impression has good predictive ability in primary care patients presenting chest pain”.

Bellow we provide a listing of each of the comments that you have sent to us after our revisions, followed by our responses and description of changes made to the paper.

Reviewer: Ana Ruigomez

1. The authors have made a careful revision and an effort in clarifying concepts and methodology issues in this revised version. The manuscript has improved, but I would like to make some final comments: It will be interesting to know the final diagnosis among those 185 patients in which the GP could not make an initial guess. Were they end-up with a specific diagnosis or not? Was this diagnosis a life threatening diagnosis or not? Could you describe these results?

   Among the 626 patients, we found 104 diagnoses (16.6%) which could be considered as potentially serious conditions. Among the 185 patients in which the GP could not make an initial diagnosis, we found 19 potentially life threatening conditions (10.2%) such as asthma (2); pleurisies and pneumonia (4); acute angina (10); unstable angina (2); Pulmonary embolism (2). The GPs ended up with a final diagnosis in all 185 patients and the principal diagnosis was the chest wall syndrome (109 out of 185).

2. Figure 1 is difficult to interpret as it is. It could just be deleted and present the results in the text as they have done. Otherwise the authors may need to extend their description of the figure to make it clear to the reader.

   As we understood it, during the previous review, details on diagnosis and when the appropriate diagnostic was reached seemed important. We therefore chose to report these only for descriptive purposes. Reporting results in text seems lengthy; we therefore chose to keep the figure, simplify it as reviewer 2 suggested it and extended the description to make the figure clearer to readers.

3. End of first paragraph of results, I understand it should refers to table 1 not to table 2.

   Thank you for spotting this. The change has been made.
4 Abbreviation for BPCO that appears in table 2 is not listed.

We made the correction and indicate the correct abbreviation in English: COPD=Chronic obstructive pulmonary disease.

Reviewer: Rudi Bruyninckx

1. I really appreciate that you read my article and used it as reference, but please do not exaggerate referring to it. Otherwise, I will have to declare having competing interests because you are referring to me too much. ;-) 

Your recently published qualitative study on the topic brings important new insights on the subject. Furthermore, you are apparently one of the authors who happen to have published the most relevant studies on chest pain management in family practice. From previous publications, we do not believe you to be subject to competing interests. We have verified our references and believe them to report the most up-to-date methodologically sound results we needed to support our findings. We believe citing you so often is only related to the fact you happen to be one of the most implicated researches in the topic; reason for which we suggested you to review our paper.

2. Page 2 and others: I do not exactly know how BMC edits ‘95%CI’, you will have to check this, I prefer ‘51.0% (95%CI: 64.5% - 52.5%)’ or ‘51% (64.5 to 52.5).’

Both suggested methods for reporting CI95% have been previously published by BMC. We chose the second method (CI95% 52.5% to 64.5%).

3. Page 3, Introduction: I suggest to skip references 4 and 5 here, and use them only in the discussion section.

Both sentences were suppressed as the results from these studies were already discussed in the discussion section.


The reference was indeed incorrectly introduced. The appropriate study was added.

5. Page 4, Methods, general practitioners: ‘Fifty-eight general...one common code’ This is a result for me, I suggest to place it there.

58 practitioners agreed to participate to the study before it started. One of them only gave CRFs with missing data and was excluded from the analyses as stated in the result section. We therefore believe that reporting the settings belongs to the method section and not the result section.

6. Page 4, Methods, reference diagnosis: ‘for the few patients. I suggest to skip ‘few’, otherwise it is a result.

The word “few” was suppressed as suggested.

7. Page 5, Methods, reference diagnosis: ‘Quality control’. How was this control performed? I did not find results of this control in the results section. So skip it here, or give information on the results.

The result from the quality control was moved to the results section as suggested.

8. Page 5, Methods, reference diagnosis: ‘One contested final.’ I suggest to skip ‘one’, otherwise it is a result.

This entire sentence was deleted and this result was moved to the result section.

9. Page 5, Methods, reference diagnosis: ‘...coronary heart disease..’ ‘Coronary heart disease’ is unclear, replace this by ‘stable or unstable.....acute angina’ like you use it in table 2.

CHD was replaced by MI, stable and unstable angina as suggested.
10. Page 5, Methods, reference diagnosis. The subheading ‘Reference diagnosis’ is too restrictive, maybe you can replace it by ‘diagnosis’ or something else.

Reference diagnosis is the term used in the STARD statement to design the method used to identify cases. We therefore believe this term not to be too restrictive and cannot come-up with a better term to describe the paragraph. We do welcome you or the editor to suggest a better term.

11. Page 6, results. ‘they did not take a guess for 185 patients’. Did I understand well that they also did not make an ‘unspecific diagnosis’ from table 2?

This is correct. “Did not make a guess” meant physicians left the field empty as they were instructed to do.

12. Page 6, results. ‘After history taking….of 8%’ This is a very interesting item. I understand that this is the result from earlier published work. You cannot give it as a result here, but I suggest to place this important information in the discussion section-previous studies. So you also refer to your earlier publication.

These results have never been published. The fact this information was collected was added to the method section.

13. Page 7, discussion, overview of results. ‘Physicians synthesize…observations’. I suggest to skip it here and combine it with ‘previous studies’. In this way you do not repeat. See also comment 1.

The discussion relating to other studies has been moved to the adequate paragraph of the discussion as suggested.

14. Page 8, discussion, strength and weakness: ‘the second limitation…is not certain’. You mention that as a weakness, for me using an independent panel (p 5, methods, reference diagnosis) is not perfect but a very acceptable solution and a strength of this study: “..diagnostic assessment after a follow-up period by an independent panel of experts, representing a “delayed type” cross-sectional study. This may not be perfect but can be the most acceptable solution.” From: The evidence base of clinical diagnosis, theory and methods of diagnostic research. Second edition, edited by Knotnerus JA, Buntinx. BMJ books, Wiley-Blackwel 2009 ISBN 978-1-4051-5787-2

We have added this methodological critical judgment in the method section adding the reference and have suppressed the comment from the limitation section.

15. Page 8, discussion, previous studies: this part of the article has to be rewritten, taking earlier remarks into consideration.

The paragraph was revised as suggested.

16. Page 8, discussion. I suggest to repeat the conclusion of the abstract.

A conclusion paragraph was added as suggested.

17. Figure 1.
   a) The evolution of the diagnosis from ‘first minutes’ to ‘end of encounter’ is very interesting. Problem is that you cannot use it without explaining this in the method section. See also remark 12.

   This was added to the methods section.

   b) I had to study the bar graphs before understanding them. I suggest to skip the ‘early undiagnosed causes’ and only use the ‘correct early diagnostic guess’, this will make it more easy to understand.

   We simplified the graph which now only reports correct diagnosis for each step of the initial encounter.
Thank you for the time you spent verifying our manuscript and for your important contribution to this publication.

We hope our comments and modifications are satisfactory.

Sincerely,

Paul Vaucher