Reviewers report

Title: Female asylum seekers with musculoskeletal pain: the importance of diagnosis and treatment of hypovitaminosis D3

Version: 3 Date: 16 August 2005

Reviewer: Peter Robert M Ebeling

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General
De Torrenta de le Jara et al. have determined the duration and speed of resolution of somatic symptoms in 33 female asylum seekers with vitamin D deficiency treated with oral calcium and vitamin D +/- 600,000 IU cholecalciferol. Somatic symptoms were present in 90.9% of patients for 2.5 years prior to the diagnosis and in 67% disappeared after 2.8 months of treatment. About 30% of patients did not respond to treatment. Attendances to emergency departments and the use of analgesics both decreased by about 50% after treatment. There was no control group. The authors conclude chronic symptoms are common in vitamin D deficiency in immigrant women, and it is often undiagnosed. Treatment leads to a resolution of symptoms in the majority with a consequent decrease in use of medical services and analgesic drugs in this vulnerable population.

Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

1. Abstract: “Hypovitaminosis D3” should be “hypovitaminosis D” as both D2 and D3 metabolites are measured by the Diasorin assay. The definition of hypovitaminosis D should be included in the Participants section. The first line of “main outcome measures” does not make sense and needs to be reworded. The treatment intervention(s) should be mentioned in the abstract.
2. Introduction: “25(OH) vitamin D3” should be “25(OH) vitamin D”. “Hypovitaminosis D3” should be “hypovitaminosis D” as noted above. The SI units for vitamin D levels in nmol/L should be used throughout rather than µg/L, to be less confusing for the reader.
3. Methods: Again, “25(OH) D3” should be “25(OH) D”, as noted above. The assay reference range for 25(OH) D should be commented upon with the definition for hypovitaminosis D being included here as well as later in the manuscript. The reader could otherwise think levels of 21-50 nmol/L were normal.
4. Page 6, paragraph 4: The units nmol/L rather than µg/L should be used here.
5. Page 7, paragraph 1: 30.3% of patients only received oral calcium and cholecalciferol, while remainder received 600,000 IU IM cholecalciferol as well. Did the 30% of patients who did not respond to treatment receive oral therapy alone? If so this should be included here. It is unlikely oral treatment at this dose would increase 25(OH)D levels into the normal range after 2.8 months. The authors may wish to cite Diamond T et al., MJA, 2005 and the corresponding editorial by Ebeling PR MJA, 2005 regarding megadose vitamin D therapy.
6. Page 9: The regimen recommended for UVB exposure in spring and summer might be appropriate for Switzerland but would not at lower latitudes (e.g. Australia where the incidence of sun-related skin cancers is very high. In this country unprotected sun exposure of the face arms and hands between 10 am and 3 pm would not be recommended, but other times would be appropriate even for asylum seekers. Such exposure of the body may not be acceptable to some ethnic groups (e.g. Muslim women).
7. The inclusion of Balkan women is a novel “at risk” group. Did these women practice veiling to explain their vitamin D deficiency?

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Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)
1. Page 10 “albumine” should be “albumin”.
2. Minor point: Are the women asylum seekers or immigrants? Both terms are used but the former appears to be more specific.

Discretionary Revisions (which the author can choose to ignore)

What next?: Unable to decide on acceptance or rejection until the authors have responded to the major compulsory revisions

Level of interest: An article of importance in its field

Quality of written English: Acceptable

Statistical review: No

Declaration of competing interests:

I declare that I have no competing interests.