Author's response to reviews

Title: Preconception counselling for the general population initiated by general practitioners in the Netherlands: results of response to the offer of PCC. (ISRCTN53942912).

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Author's response to reviews: see over
Leiden, May 3rd 2006

Dear Editor,

Thank you for considering our paper “Preconception counselling for the general population initiated by general practitioners in the Netherlands” (ISRCTN53942912) for publication in your Journal and the possibility to react on the comments of the reviewers. The title of the paper was changed in ‘’. Enclosed you find a detailed reaction on the comments of the reviewers and the revised manuscript.

We hope you find the revised paper suitable for publication in your Journal.

Yours sincerely,

Also in behalf of the other authors,

Joyce Elsinga
Reaction on the comments of the reviewers

Reviewer 1 (Leo P. ten Kate)

Major Compulsory Revisions
1. The original title was changed to “Preconception counselling for the general population initiated by general practitioners in the Netherlands: results of response to the offer of PCC.”
2. The objective of the abstract has been adjusted accordingly. It is phrased as follows: To investigate the extent to which women contemplating pregnancy can be reached when a PCC programme is routinely offered by general practitioners (GPs).
3. The study Parents to be was designed as a randomized control trial to study the effect on adverse pregnancy outcome. In this article we present the results of the response to the offer of PCC. We made changes in the methods section of both the abstract to clarify this. We also edited the paper to make this clear.
4. The results and the conclusion section of the abstract have been adjusted.
5. General practices were matched on both practice and GP characteristics (e.g. practice size, age). Mostly pairs of general practices were formed, but sometimes clusters contained more general practices due to the location. Within each cluster general practices were randomised to either the control or intervention group.
6. We agree that circumstances can change over the years. Therefore, we considered reasons for exclusion that were related to the partner as temporary social circumstances. In the third year of study, women who were excluded for these reasons were reviewed again. Adaptations in text have been made to clarify this.
7. In the method section it is specifically stated that all pregnancies in this age group (refers to women between 18-40 years) were collected.
8. The final response of primarily non-responders is included in the overall response to the invitation. The sentence was changed accordingly.
9. The reviewer correctly indicated that on page 10 the year mentioned and referring to table 5, was inconsistent with table heading, which has been corrected.
10. We find that the used method to offer PCC can be compared with other screening programmes in the GP practice like for instance the cervix and mammal screening programmes in the Netherlands. The response to these programmes primarily lacked behind as we noticed with the introduction of our PCC programme. The third paragraph on page 11 has been rephrased for a better understanding.
11. The exclusion by the GP appeared to be a major issue. We, therefore, recommend to study how this exclusion may be reduced. One possible method, in our opinion, is sending the invitation by a local health authority. We added this to the paragraph.
12. Table 1 demonstrates a difference in the number of risk assessment questionnaires sent and the number of women contemplating pregnancy within one year. Women, who had indicated to have become pregnant after responding and before the risk assessment questionnaire was sent, did not receive a questionnaire. In the first year some women only applied for participation by phone, which was not recorded by the doctor’s receptionist. This is indicated in the discussion section of the paper.

Minor essential revisions
1. The reviewer correctly mentioned that we did not ask at which point in time one would be interested in PCC, but that we asked for the moment in time they expect
to be contemplating pregnancy. This was done for research purposes. As we did not want to overload the GP’s, it was decided to invite those who wanted to become pregnant within one year. This has been clarified in the method section.

All other suggestions have been taken into account.

**Discretionary revisions**
1. In the abstract we mentioned the general population as a “presumed low-risk” population. The reviewer is correct that officially it is an unknown-risk population, but most researchers (wrongfully) assume it to be a low-risk population. We therefore preferred using the term “low-risk population”, but purposely added “presumed”.
2. “malformation” has been changed into “abnormality”
3. The reference has been moved
4. Unfortunately there are no English references available. We therefore followed the suggestion of the reviewer and translated the titles.
5. We changed the reference.
6. This is truly the full title of the journal.

**Reviewer 2 (Andrew E. Czeizel)**
We appreciate the support of the reviewer for preconception counselling. As we do not want to disappoint the reader we changed the title of the paper that now indicates that we will present results of the response.

**Major compulsory revisions**
1. In both the introduction and discussion the obligatory PCC system that was introduced in Hungary and China is mentioned as such.
2. The mentioned scientific error was correctly noticed and has been adapted accordingly.
3. In the Netherlands almost everyone has a GP. If medical attention is needed you attend the GP, who treats you or refers you to a specialist if necessary. We also wanted to use this system for preconception counselling, i.e. to refer someone only if necessary. As it is insufficiently clear who has a high or low risk, all women between 18–40 years of age were invited. Only after completing the risk assessment questionnaire and after counselling by the GP, a clear distinction can be made into high and low risk couples. If necessary, couples were referred to a specialist for more information or treatment.

In another paper we have described the prevalence of risk factors among the couples that completed the risk assessment questionnaire. It appeared that all but one couple had at least one risk factor for which personal counselling was indicated. Most of the time this could be handled by the GP. In the other case the woman and her partner were referred to the relevant specialist. This is in accordance with the findings in the Hungarian system as described by the reviewer and thus justifies an approach for the general population.

4. Ideally, PCC should be part of prenatal care as a whole. As PCC is a new concept in the Netherlands we first wanted to study if PCC could be carried out by the GP in a systematic and programmatic way for the general population in the Netherlands. Incorporation of PCC in our usual prenatal care system is one of the next steps.
5. Our study was aimed at providing information about risk factors and preventive measures, and to identify personal risk factors. If needed, a referral to a specialist was considered. This is in our opinion the first step of preconception care and we therefore found it too pretentious to call it preconception care and called it preconception counselling.

**Minor essential revisions**
1. We adjusted the mentioned sentence.
2. We limited our offer of PCC to women aged 18-40 year as the majority of pregnancies occur in this age group in the Netherlands.
3. A reference was added to this paragraph for a better understanding.