Author's response to reviews

Title: Interventions for renal vasculitis in adults. A systematic review.

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Author's response to reviews: see over
Reviewer's report
Title: Interventions for renal vasculitis in adults. A systematic review.
Version: 3 Date: 19 March 2010
Reviewer: Catherine Meads
Reviewer's report:
For clarity, I have copied the author response letter here and my current
comments in response are marked with ***
1. you must explain why you have included quasi-RCTs as normally this will not
be included unless there is a specific reason. What forms of Quasi-RCT were
you willing to include?
Quasi RCTs were included in the protocol prior to the search strategy being
implemented. Good quality RCTs are very hard to come by in Renal Medicine,
we therefore used as wide a search as possible to maximise the available data.
In the final event, there are no quasi RCTs in the study.
***In which case you need to state "we included Quasi-RCTs because good
quality RCTs are very hard to come by in Renal Medicine, we therefore used as
wide a search as possible to maximise the available data" in your methods
section and "there were no quasi RCTs included in the systematic review" in the
results section***
Done

2. did you search for unpublished studies?
Yes we have not found any as yet
*** in which case you need to state this***
Done

3. did you include studies in foreign languages?
Yes, this included getting a chinese abstract translated, only to find it was not a
randomised study.
*** in which case you need to state that you did not exclude foreign language
studies***
Done

4. did you check reference lists to find other studies?
Yes, lots of them
*** this is now in appendix I***
It is unchanged. I'm not sure what this means

5. You MUST put in a flow diagram of the study selection process. How many
titles and abstracts did you sift? How many full papers did you examine? What
were the reasons for the excluded full papers?
Agreed, included.
*** yes but you've put it in twice***
It has appeared twice because It is in the main article and then I have to submit it separately as a
figure. I believe the software from the publisher then puts them back together again. I keep them in
my main file because it manages the references between text and figures and the List of Figures.

6. What was the quality of the included studies? You say you assessed but how
did you use the assessment to indicate the believeability of the results?
The quality of the studies is highly variable but, in most of the outcomes,
heterogeneity is low.
There are no major issues as to interpretation of the studies. Whilst some of the
early, small and poor quality studies are rather difficult to interpret, the larger
higher quality studies show similar results. The issue of “believeability” is
therefore not a major problem in the current study.
*** I refer you to your response above where you say that "good quality RCTs are very hard to come by in Renal Medicine". You do not seem to have taken into account recent publications demonstrating how a few drug companies seem to be into 'information management' Just because studies show similar results it doesn't necessarily mean that they are reflecting true estimates of effectiveness. You have done a standard chard of Jadad- style quality factors. This shows that many of the included studies did not specify randomisation method, and that allocation was unclear, and that blinding was absent or unclear, and that many did not use ITT. So I do not understand how you can say that believability of the results was not an issue.***

I entirely agree that the quality of the studies is not good in many cases. The earlier studies are not only poorly randomised but also have many patients included that would no longer be acceptable in these sorts of studies. I am very much aware of the practices of the pharmaceutical industry (and the incredibly poor response of the medical profession) but this practice has little or no impact on the current literature into vasculitis. This is an area where there is very little money for companies to make. All of the higher quality studies here are investigator initiated with minimal drug company involvement. When the higher and lower quality studies come out with very similar results, then I do say that the believability is not an issue and I think that, overall that is correct, certainly in this field where there is little in the way of ghost-written nonsense.

7. Which studies were the Quasi-RCTs? Did their results differ systematically from the true RCTs?
As above, there are none.
*** see comment above***

Done

8. You need to give some details of the patients in the trials. What ages were they? Gender? Ethnicity? Etc
Yes, currently this is not in the paper. It is a table in the review but I was not sure that this detail was essential for the paper. It could go in the text or as a table and I would be happy to add it. Most appropriate would probably be a table but there are quite a few of them already.
*** BMC is an electronic journal with space for plenty of ancillary files. If the details are in the Cochrane review you could just tell people to look there***

Done.

minor essential revisions
1. the review needs to be written according to the PRISMA guidelines, including the abstract
I have worked to format the paper according to the instructions for authors. I have also gone through the 27 item PRISMA worklist. The full Cochrane Review complies with the worklist but a paper summarising the full review simply cannot fulfill all the Prisma criteria. If there are any thought to be essential that I have missed I am happy to put them in.
*** see other comments***

No action

2. the abstract conclusions seem to just have more results in . Please move these to the results section and put what you conclude from the systematic review in the conclusions section.
The Conclusions are a summary of the most notable results of the available evidence. They are a significant departure from some currently held beliefs.
in which case you need to say this in your conclusions (and move the results into the results section)***

**Done**

3. p4 the sentence "The treatment of goodpastures ....." in the background section does not make sense to the general reader as you say you are reviewing PRGN then exclude some forms RPGN but don't explain why these are any different from other forms of RPGN and why they should be excluded. - your figure captions don't explain what the forest plots show but seem to be statements of conclusion. Please change them to say exactly what the forest plot is.

Added an explanatory phrase in background.

***good to add explanation. However, you now have two sets of Forest plots, one with the original inappropriate captions and the others with no caption at all***

Captions changed to be more descriptive. The two sets of plots is the same problem as the flow chart as above.

4. you don't explain about induction and maintenance agents in the background section yet an understanding of this is expected in the discussion section. Please make the two sections match. For example, exactly what is Scr<500uM?*

The concept of inducing remission was present in the second paragraph of the background followed by scaling back of treatment. I have specifically included the words remission induction and maintenance therapy to clarify. Scr is referred to in the table of abbreviations as Serum Creatinine. 500 uM is a concentration in SI units.

*** this comment is all about making the article comprehensible to the general reader, rather than expecting all to have in-depth knowledge - which also is part of my comment to the issue 2 above***

No action required.

5. You start to describe cost benefit studies in your implications for research. Do you mean cost-effectiveness as it is very rare to estimate the financial cost of health effects and much more common to estimate utility. Are you actually describing a cost minimisation activity?

Yes, you are correct, I should have termed it cost effectiveness. This is a critical issue for example in the use of rituximab where it has equivalent efficacy but costs probably several hundred times as much as cyclophosphamide. It is widely held that rituximab has fewer long term side effects but that is not well proven.

***Can you say this in your conclusions?***

**Added in Implications for research.**

discretionary revisions

1. If you were developing a guideline for treatment of this condition, which drug would come first and which next etc? What additional information would you need to be able to construct the guideline (ie which comparative studies are missing?)


The guideline I have already co-authored.

*** so what future research did it suggest, and how do they link with this systematic review research recommendations? Can you put this in your
conclusions?***
The guideline did not include suggestions for future research and also did not include several of the studies that are part of this review. My next job is to stir up a revision!

Level of interest: An article whose findings are important to those with closely related research interests
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'