Author's response to reviews

Title: Clinical pharmacy activities in chronic kidney disease and end-stage renal disease patients: A systematic literature review

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Author's response to reviews: see over
Cover Letter
for submission of the revised publication

Clinical pharmacy activities in chronic kidney disease and end-stage renal disease patients: A systematic literature review
By Gunar Stemer and Rosa Lemmens-Gruber

Vienna, 29.06.2011

Dear Editor.

On behalf of my co-author, I am submitting a revised manuscript with the following revisions made to the initial version and remarks on the concerns raised by the various reviewers.

Concerns of reviewer T. Nguyen:
.) Not all of the included controlled trials were randomised (see reference 19). That’s why ‘randomised’ was written in brackets. The correct abbreviation NKF-KDOQI is now used consistently.
.) References were harmonised according to the BMC Nephrology reference style.

Concerns of reviewer T. Dowling:
.) The supplemental tables are meant to be integral parts of the manuscript and so we integrated them directly into the manuscript. On page 9, the first sentence under the paragraph General study characteristics was amended with additional details on the information (e.g., interventions, outcomes, results) listed in the tables. We chose to work up the main study results and display them in the tables 2 (CKD) and 3 (ESRD). Thus, the reader can overlook and compare the individual study results very easily. In our opinion, a narrative listing of the individual study results in the Results section would be unclear and lead to confusion.
.) On page 10, under the paragraph Scope of clinical pharmacy activities, the main disease areas identified were amended. Table 4 was worked up, restructured, and more details were added.
.) For better and easier understanding, references [17-19, 24-27] were added for those studies reporting on clinical pharmacists’ disease management programmes.
... We couldn’t identify any studies explicitly addressing CKD progression factors (e.g., proteinuria) by applying our search strategy. We state this at the beginning of page 12.

We rewrote the beginning of our discussion section (page 12-13). The following part on the clinical pharmacist’s responsibilities and published evidence was amended:

Potential responsibilities of clinical pharmacists may comprise attainment of blood pressure, glycaemic, and lipid goals, and the early evaluation and treatment for proteinuria, anaemia, and secondary hyperparathyroidism, among others [10]. Optimal control of hyperglycaemia, including maximal suppression of urinary albumin excretion by angiotensin-converting enzyme inhibitors (ACEIs) or angiotensin II receptor blockers (ARBs) in diabetic patients with persistent microalbuminuria, and hypertension can limit progression of CKD to ESRD. Evidence of improved glycaemic and blood pressure control and decreased levels of microalbuminuria through clinical pharmacists’ involvement in patient care is published [36-38]. However, due to our search strategy, studies explicitly addressing only these latter aspects are not included in this systematic review. Furthermore, no study of clinical pharmacy services in CKD patients investigating the slowing down of disease progression could be identified.

The study by Borenstein JE et al. shows the beneficial impact of physician-pharmacist coworking on hypertension, which is undoubtedly an initiation factor of CKD and influences the progression. The study, however, doesn’t not report on CKD or ESRD patients.

We tried to address the concerns of the reviewers with greatest care and thank them for their valuable remarks and constructive feedback on our manuscript.

Sincerely,
Gunar Stemer