Author's response to reviews

Title: Impact of renal dysfunction on long-term outcomes of elderly patients with acute coronary syndrome: a longitudinal, prospective observational study

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Author's response to reviews: see over
Major Compulsory Revisions
- The percentage of patients with unstable angina (UA) is so high to reflect contemporary populations of patients with ACS. What was the reason of that so high proportion of patients? What were the criteria used to classify patients into STEMI, NSTEMI and UA?

Yes, here the proportion of the patients with UA is high than previous reported 30% patients who had STEMI from the National Registry of Myocardial Infarction. As for the criteria used to classify patients into STEMI, NSTEMI and UA is referred to the ACC/AHA guidance. We think the reason is for that most of the patients who were hospitalized to our department were Beijing residents. They enjoyed the convenience of medical conditions and accepted periodic medical examinations. So it is more easier and earlier to find the diseases before severely.

- 19 patients who were lost during follow-up, what were the reasons of that high % of missing data during follow-up?.

As for part of the patients enrolled in this study is from across the country and even the remote areas, with inconvenience transportation and contact. The other reason for missing data is because the time of follow-up is relative longer than usual. It is very regrettable for us.

- Authors should discuss that patients with more severe renal impairment had undergone less frequently coronary angiography. Did the authors considered these procedures in the multivariable Cox analysis?

In clinical practice coronary angiography is a relative contraindication. For the surgeon, adequate preoperative assessment of renal function and communication with the patients and their families. Do everything, including hydration before and after the CAG, dialysis, prevention of contrast induced nephropathy or renal function further damage, are very important. This is the reason why the patients with more severe renal impairment had undergone less frequently coronary angiography. We also considered these procedures in the multivariable in the cox analysis.

- I suggest including a Table reflecting the univariable and multivariable effects (hazard ratios) of all factors used in these analyses.

See table 5.

Minor Essential Revisions
- Tropinin T is not a cardiac enzyme. What was the cut-off point of the diagnosis of myocardial infarction using cardiac tropoinin T. TnT determination have been standardized, Roche has solved the cardiac muscle TnT cross section with skeletal muscle and with equal specificity with TnI in the ACS. And TnI is different with use of different instrument manufacturers, the corresponding reference values are not the same.

- Table 2: values of serum creatinine are expressed by mg/dL, but these values are unbelievable high.
Our hospital is a general hospital and the kidney department is one of the largest Kidney Center in China. So here we had a lot of patients with severe CKD even regular dialysis. Part of these patients transfered to our department for recurrent chest discomfort.

Reviewer2
Major Compulsory Revisions
my comments are as follows, but not restricted to these,
1. the language quality needs to be further improved.
Revised.
2. in the ABSTRACT, the definition of severe and mild RD should be stated clearly.
Severe RD means GFR less than 30ml/min/1.73 m² and had revised in the abstract.
3. the patients enrollment duration was inconsistent between the ABSTRACT and the STUDY POPULATION.
This mistake had corrected.
4. the definition of renal failure should be provided in the text. is it equal to severe RD? and AKI?
Renal failure means the GFR less than 15ml/min/1.73 m².
5. all abbreviations should be used formally, such as DM, IHD etc, especially when appeared first time.
Revised.
7. the units of main lipids in table 2 are incorrect.
Revised.
8. the follow-up and UCG measurement methods should be provided in the text.
Revised.
9. the position of reference 12 should not be included in the part of RESULTS, try to find where appropriate.
Revised.
10. in table 3, the units and p values were not correctly presented, what does *mean? which data means percentage? all tables need to have one criteria
Revised.
11. the page format in all references should be consistent.
Revised.
12. in figure 1, we could not find the survial curve of patients in group V?
Revised.
13. the part of DISCUSSION should be written more concisely and concentrated, based more on the results of the present paper.
Revised.