Author’s response to reviews

Title: Generalizability of guidelines and physicians’ adherence. Case study on the JNC VI guidelines on hypertension

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Version: 3 Date: 1 Jul 2003

PDF covering letter
Title: Generalizability of guidelines and physicians’ adherence. Case study on the JNC VI guidelines on hypertension.

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II Revision

Dear Editor –

Thank you for the interest shown in our paper. The manuscript has been reviewed, and we tried to address most of the issues raised by the reviewer. Below you find a point-by-point reply.

Best regards

Claudio Pedone
Specific comments

1) As per reviewer's suggestion, we modified the last sentence of the introduction trying to make it less ambiguous.

2) We modified the conclusion in the abstract, making them more conservative.

3) We agree with the reviewer on the fact that inclusion/exclusion criteria of clinical trials are basically determined by the study design. The reviewer argues that "the implication that patients diagnosed as hypertensive in the community ... do not reflect inclusion criteria, does not appear to invalidate their treatment". This is true, but our argument is that it is not easy to predict the risk/benefit ratio of any given intervention when we try to extrapolate the finding of a study to populations with different characteristics. The absolute benefits of an intervention will be less evident in low-risk patients, while the risk for adverse reactions is likely to be higher in high-risk patients.

4) “The conclusion that baseline risk was the major determinant in the decision to treat is not fully justifiable”. All the people included in our sample should receive drug treatment according to the JNC VI recommendations. However, we found a higher treatment rate in people at higher risk. Treatment rate was 74.6% in those in the lowest risk group, and 90.3% in those in the highest risk group, with a linear increase of treatment rates across the risk groups. Furthermore, most factors related to cardiovascular risk (myocardial infarction, stroke, heart failure) were positively related to drug treatment prescription. It is true that the 95% CI for these variables span the unity (table 4), but in this case the data clearly point to a positive association. To provide an example, we found that having had a stroke was associated with a two-fold probability of having a prescription of an anti-hypertensive drug. This point estimate was also compatible with a 10% reduction of the probability of being treated, or with a 400% increase. Although not nominally significant, we believe that this data support our conclusion.1

5) All the limitation cited by the reviewer are already mentioned in our discussion, except the fact that exclusion criteria for trials are inclusion criteria for guidelines. This is exactly the issue we were trying to point out: guidelines must base their recommendation on the individual risk profile, but in doing so they need to extrapolate trials’ results to population having characteristics different than the ones of people enrolled in clinical trials.

6) Table 4. The NHANES questionnaire contained two question: one was “Have you ever been told to take anti-hypertensive medication”, the other was “Are you currently taking an anti-hypertensive medication”. We decided to use the first one because it investigates physician’s prescription rather than patient’s compliance.

7) We changed the footnote in table 3.