Reviewer’s report

Title: Real-life use of fluticasone propionate/salmeterol in patients with chronic obstructive pulmonary disease: a French observational study

Version: 1 Date: 26 November 2013

Reviewer: Andrea melani

Reviewer’s report:

I have reviewed the manuscript. Real life studies are always interesting to publish, but the present survey needs to be largely improved for publication.

I insert some points requiring improvement

• Minor revision: Please specify the types of investigated comorbidities, as in table I see only cardiovascular (and hypertension) comorbidities (not osteoporosis, anaemia, diabetes and so on). Please also detail the rate of patients having at least a comorbidity; currently I read that approximately half of patients had a comorbidity

• Minor revision: Authors often report respiratory failure as a comorbidity. However, it is not usually considered as a COPD comorbidity. Correctly, authors specify that chronic respiratory failure was used in GOLD COPD 2003 guidelines. How many did patients suffer from chronic respiratory failure? In table 1 they report 31% of the GP group and 37% of the pulmonologist group. On the other hands, they report in additional Table 3 that Oxygen therapy (I think LTOT) was prescribed to 6% of GP group and 15% of pulmonologist group. Please explain this difference. Please specify whether the term respiratory failure refers to either chronic respiratory failure or acute respiratory failure or both conditions.

• Minor revision: In additional table 3 you specify that 5% of GP group and 15% of pulmonologist group had nursing care; what does it mean? Please explain this point

• Minor revision: Please, If available, specify how many patients were overweight and how many were obese

• Major revision: Summary of product characteristics indicates FSC use for the symptomatic treatment of patients with COPD, with a FEV1 <60% predicted normal (pre-bronchodilator), a history of repeated exacerbations and who have significant symptoms despite regular bronchodilator therapy alone. Differently, authors write that FSC is indicated when 1) FEV1<60% pred, 2) at least two exacerbations and 3) prior continuous bronchodilator therapy with either a LABA or a LAMA. There is a relevant difference

• Minor revision: I understand that when you write “A total of 710 patients were included”, it means that “A total of 710 patients received a new prescription of SFC and were included”. If yes, please correct

• Minor revision: In additional file 2, you write “Non participating patients had
similar age… as included patients”. I don’t understand this point. Does it mean that you have a database of COPD patients who did not receive a new prescription of SFC? In the same file you describe that patients without FEV1 data were less likely to have experienced respiratory failure. I don’t know even this sentence. Is it an acute episode?

• Minor revision: In additional file 3, you write that a common cause of SFC prescription was patients’ non-compliance. If you some additional data regarding it, please add them

• Minor revision: In the Table 2, I see that the pulmonologist group of patients had more emergency visits and hospitalizations, but less courses of antimicrobials and oral corticosteroids. Probably these points needs to be discussed.

• Minor revision: Authors state that pulmonary hypertension ranged from 3.5% to 9%. Please explain how it was evaluated

• Minor revision: Authors described that blood gas levels are recorded at inclusion. If available, at least for some patients, add these results and evaluate the concordance with patients having chronic respiratory failure

• Major revision: Authors state that they recorded cough, wheezing and sputum at baseline and at follow-up visits, but they do not describe these results at follow-up and the differences from baseline: is FSC useful to improve these symptoms?

• Minor revision: Page 3, line 4 : the term preference is better than tolerance

• Minor revision: The first GOLDCOPD guideline included ICS/LABA use for patients with FEV1<50% pred. A post-BD FEV1 <60% pred is currently included into the FSC leaflet after several studies and mainly the TORCH, including the post-hoc analysis by Jenkins, Respir Res. Please introduce this point into the introduction section

• Major revision: Authors state that the present study is a prospective one. Then they report that data are collected at inclusion and at follow-up visits. However, it is not clear the number and the period of follow-up visits; were all questionnaires self-compiled at follow-up visits? if yes, specify it and added, if available, some relevant results: i.e. does FSC prescription reduce exacerbations or dyspnea or improve FEV1 with respect to the period prior to FSC prescription. If questionnaire were compiled at baseline, (it is not specified in Table 1) and other prospective results are lacking the term of prospective does not attain to the current study

• Minor revision: To table 1 you report that self-managed exacerbations are 49% for GP group and 80% for pulmonologist group. Had these patients a written plan for self-management? Please also specify the overall rate of exacerbations (self-managed and physicians-managed)

• Minor revision: Page 5, line 10: “…on the day of the enrolment visit….”

• Major revision: Interestingly, you insert a calculation of potency for the study. However, I do not understand your calculation of potency. Do you refer to some previous data or reference?
Major revision: Correctly authors report that only approximately 7% of consulted physicians agreed to take part to the study. In addition, only 162 of 419 GPs and 88 of 172 pulmonologists enrolled patients. This is a big bias. Moreover, I think that physicians knew the aim of the study when they decide to participate and possibly participants were quite conservative in their prescription of FSC and this can alter real life prescriptions.

Minor revision: To page 6, last line, insert “… with the national population of physicians. To the same line I prefer “eligible, but not participating” and not “inactive”

Minor revision: To page 7, paragraph “COPD profile” authors organize a comparison between physician's belief and GOLD2003-severity as a whole. It would be interesting to evaluate the concordance between physician's belief and GOLD2003-severity in the subgroup with spirometry.

Minor revision: Authors report that QoL score is similar between GP and pulmonologist groups. However, the GP group had better FEV1 and MRC score. Please discuss this point into the discussion section.

Major revision: To the end of page 8, I read that approximately 20% of patients used an FSC dosage less than suggested for COPD patients (50/500 twice daily); moreover, another 20% was using 2 doses of 50/500 FSC twice daily; these dosages are not appropriate. In table 2, I see that at the time of FSC prescription, 11% of GP added another LABA (?) and 9% another ICS; although in a slightly lower rate, 4.3% of pulmonologists also added another LABA (?). If these results are true, please discuss them; really, in my experience I did never see COPD patients using more types of LABAs simultaneously.

Major revision: Authors distinguished between patients naïve and experienced with ICS; however, prior ICS usage does not necessarily is a correct prescription. So this difference does not sound.

Page 3, line 14. LABA/ICS are a first line option, not the first line option.

English language has to be edited.

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

Quality of written English: Needs some language corrections before being published.

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

No financial competing interest.