Author's response to reviews

Title: Comparison of general practitioners and rheumatologists' prescription patterns for patients with knee osteoarthritis

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Author's response to reviews: see over
Dear Editor,

Please find enclosed our revised manuscript (MS ID: 2915259484789810) entitled “Comparison of general practitioners and rheumatologists' prescription patterns for patients with knee osteoarthritis”.

We have addressed all the issues, and point-by-point responses to the reviewers’ comments are detailed.

We have provided a number of changes according to the reviewers’ suggestions. This version has been approved by all the authors who have given necessary attention to ensure the integrity of the work.

We thank the reviewers for their very helpful work and you for this opportunity to improve our paper.

We hope that you will now consider our revised manuscript acceptable in BMC Musculoskeletal Disorders.

With kind regards

Dr Pascal Richette
ANSWERS TO REVIEWERS
MS ID: 2915259484789810

REVIEWER 1

General comments. This is a well written study, pertaining to an important and increasing population with OA knee. The topic is of interest and the authors have focused on a whole of nation survey, which provides an overview of OA knee treatment in France. The abstract is clear.

We thank the reviewer for the positive comments and thorough evaluation of our paper.

Comment 1. Please state the relationship between GPs and RHs. Are RH patients referred from GPs or can consumers approach Rhs directly? This may have significant impact on types of patients seen.
Response. In France, patients can freely consult a specialist, without being referred from GPs. We have inserted this information in the discussion section, p.9 of the manuscript.

Comment 2. Please state the total eligible population of GPs and RH and % invited to participate.
Response. As stated in the patients and methods section, 7,451 GPs and 1,777 RHs were asked to participate; 1,194 GPs (16.0%) and 225 RHs (12.7%) agreed and were sent questionnaires. Finally, 808 GPs (67.6%) and 134 RHs (59.5%) recruited patients.

Comment 3. Were RHs oversampled in view of their much smaller numbers than GPs?
Response. We thank the reviewer for this relevant remark. In a sense, the reviewer is right because there were about 6 times more GPs than RHs who included patients in this survey, which is by far less than the ratio of GPs/RHs (r=40) in France. However, we aimed to compare the practice of a representative population of GPs and RHs, and this was the case because the demographics of the GPs and RHs who participated in this study did not significantly differ from those of GPs and RHs in France in general in terms of sex, age and number of years of practice.
We estimated that the number of patients needed for this survey was 1,536, and we thus have invited 1,400 physicians to participate. If we had kept the ratio of 40 GPs for one RH, it would have meant that we would have included only 35 RHs, which would have
underpowered our survey. As a consequence, we chose to include 200 RHs, as we believed that it would provide a representative population of these specialists in France.

**Comment 4.** Do GPs have ‘special interests’ ie could there have been some with a special interest in rheumatology and was this assessed?

*Response.* This is an interesting remark. To avoid this potential bias, GPs were randomly selected from the CEGEDIM registry and RHs from the French Society of Rheumatology registry. This is indicated in the patients and methods section.

**Comment 5.** As treatment is the key focus of the survey please describe in more detail the definition of these as used in the survey; NSAIDs vs low dose NSAIDs, physical therapy (?GP prescribed or physiotherapy), SYSADOA etc

*Response.* Because our questionnaire was pragmatic, we did not ask the physicians to accurately provide the drug name for acetaminophen, weak opioid analgesics, NSAIDs, low-dose NSAIDs…etc. However, in France, the low-dose NSAIDs are NSAIDs sold over the counter and are ibuprofen (up to 1200 mg), ketoprofen (up to 75 mg/j) and naproxen (up to 660 mg/j). Available SYSADOA are chondroitin, glucosamin, diacerein, and avocado/soybean unsaponifiable. This is now indicated in the patients and method section. Finally, physical therapy needs to be prescribed by a physician.

**Comment 6** Please consider the reasons for RHs patient being systematically different to GP patients in more detail

*Response.* Indeed, we found that patients who consulted their GPs had more severe knee pain, with higher disability. We believe that these differences might be due in part to patients’ more limited access to RHs (for financial reasons for instance), which leads patients with painful disease to consult GPs more often. Another explanation, suggested in a previous British survey (Ref 17), could be that a mixture of physical, social and psychological factors might predict visits to GPs, that may explain the different clinical profile of patients with knee OA who consulted GPs. We have added this point in the discussion section.

**Comment 7.** A key difference is use of intra-articular therapies by RHs. Can the authors comment on the evidence (or lack of evidence) about the relative effectiveness of low dose NSAIDs and SYSADOA. Are patients not seeing RHs being potentially disadvantaged and how would this question be addressed in future studies.
Response. We fully agree with the reviewer on the relative effectiveness of low-dose NSAIDs and SYSADOA. There is indeed an extensive literature on this debatable subject. However, we would prefer to not discuss that point, because it was absolutely not our objectives to assess the efficacy of SYSADOA or low-doses NSAIDs in patients with OA. In the same way, our survey does not compare the efficacy of treatments modalities from GPs or RHs. It would be of course of interest to assess this point.

Comment 8. Abstract; please write SYSADOA in full
Response. The acronym SYSADOA is now written in full.

Comment 9. Background; the last sentence presents results and should be removed.
Response. Accordingly, we have deleted the least sentence of the abstract.
REVIEWER 2

General comment. The authors describe the results of a prospective, national survey on the prescription modalities of GPs and rheumatologists for symptomatic knee OA. The topic has been addressed by an other studies published so far, with similar results.

We thank the reviewer for the interest in our work and helpful comments.

Comment 1. The number of physicians and patients involved is quite small, and this makes difficult to draw definite conclusions on different treatment modalities.

Responses. As detailed in the patients and methods section, the sample size was calculated to provide a satisfying precision in the worst situation for ordinal data (rate of 50%). With an alpha risk of 5% and an expected precision of 2.5%, the number of patients needed was 1,536. Because the expected rate of practitioners actively recruiting patients among those giving their consent to participate was 55%, we invited 1,400 physicians (1,200 GPs and 200 RHs) to participate.

Comment 2. Some differences in patients characteristics are somewhat unexpected and deserve a more detailed discussion. In particular patients seen by GPs appear to have a more severe disease. Waiting list or limited access to rheumatologists does not sound as the unique explanation. It should be interesting to know if GPs referred (some) patients to rheumatologists or to different specialists (orthopedics, physiatrists) as well as if patients seen by rheumatologists were or not referred to by GPs.

Responses. We agree with the reviewer that the limited access to RHs might not be the sole explanation for the different clinical profile of patients managed by GPs or RHs. We also believe that providing the percentage of patients referred by GPs would be of interest, but unfortunately, we do not have this information. However, we have added in the discussion section that “as shown in a previous British survey, a mixture of physical, social and psychological factors might predict visits to GPs, that may explain the different clinical profile of patients with knee OA who consulted GPs”.

Comment 3. To better understand data on NSAIDs use it should be reported when the study was carried on: in particular before or after the reports on cardiovascular toxicity of coxibs and the subsequent warnings by FDA and EMA on NSAIDs and Coxibs about cardiovascular toxicity.
Response. As requested by the reviewer, we have added in the patients and methods section that the questionnaires were sent in May 2008.