Reviewer’s report

Title: Comparison of AIMS2-SF, WOMAC, x-ray and a global physician assessment in order to approach quality of life of patients suffering from osteoarthritis.

Version: 1 Date: 30 August 2005

Reviewer: Agustin Escalante

Reviewer’s report:

General

The authors have conducted a cross-sectional study in a sample of patients with OA. The aim seems to have been to identify associations with patient quality of life, as rated by the general practitioner. Several areas of weakness are identified, that if corrected, may raise the quality of this manuscript.

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Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

1. The major weakness of this study is the omission of multivariable techniques from the analyses. As the authors recognize in page 9 (top paragraph), GP assessments are "influenced by a complex mixture of multiple factors". Despite this, authors seem to have limited their analytic approach to a series of bivariate comparisons, and simple stratification based on age, sex and education. Authors are urged to apply more advanced multivariable techniques (e.g. multivariable regression) to identify factors independently associated with GP ratings of patient quality of life.

2. The Kellgren-Lawrence (KL) OA severity scoring scheme is a five level ordinal scale. Averaging these scores is of questionable validity (as was done in Tables 1 & 2). More acceptable and informative would be to provide the number of patients in each category, separating hip scores from knee scores. See following point related to this.

3. OA of the hip and knee often occur separately - i.e. patients may have one without the other. Averaging the KG score as the authors have done, may lead to falsely low scores in patients with discrepant hip knee involvement. (e.g. a patient with a grade 4 knee and a grade 0 hip would have an average score of 2. In such a patient, the grade 4 knee may be the primary determinant of QOL, but this would not be picked up because of the score averaging). Authors are urged to disaggregate the KG scores into their individual joint components, and repeat the comparisons with the QOL ratings using the individual joint scores.

4. The validity & reliability of the German version WOMAC and AIMS-SF should be documented, as should that of the VAS QOL scales.

5. A graph showing the frequency distribution of the GP VAS QOL scores might make the paper more informative.

6. A table or graph showing the distribution of the GP VAS according to joint-specific KG score might make the paper more informative.

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Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

7. Some of the correlation coefficients in the 0.3 to 0.4 range are described as "weak". Knowledgeable readers may object to such terminology. Authors may wish to omit these descriptors, in favor of simply stating the value of the coefficient. Readers will draw their own conclusions about their strength or weakness.

8. Acronyms and abbreviations should be defined upon first use in the abstract.

Discretionary Revisions (which the author can choose to ignore)

9. No one argues with the need to understand patient QOL, as viewed by the patient. Readers, however, may need help understanding why it is important to know how doctors rate the quality of life of their patients. Additional discussion on this issue would be welcome.

What next?: Unable to decide on acceptance or rejection until the authors have responded to the major compulsory revisions

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

Declaration of competing interests:

'I declare that I have no competing interests'