Title: Epidemiologic profile of otorhinolaryngological, head and neck disorders in a tertiary hospital unit in Greece: a challenge for general practitioners?

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Version: 2 Date: 15 May 2006

Author's response to reviews: see over
Re: Epidemiologic profile of head and neck disorders in a tertiary hospital unit in Greece: a challenge for general practitioners?
MS: 4856428879736885

15-May -2006

Dear editor

We would like to submit the revised manuscript newly entitled “Epidemiologic profile of otorhinolaryngological, head and neck disorders in a tertiary hospital unit in Greece: a challenge for general practitioners?” which has been corrected according to the comments of the reviewers. We have also performed some editing and formatting changes in the revised manuscript according to the editorial suggestions (language, ethics, and acknowledgements).

All co-authors have read and approved the changes made in the revised manuscript. Taking this opportunity we would like to thank both reviewers for the constructive and helpful suggestions and for the thorough reviewing process.

We are looking forward to hear from you.

Yours sincerely,

Dr. Emmanuil I. Drivas
POINT BY POINT REPLY

Below we describe the changes we have made:

First Reviewer

**General:**

Reviewer’s comment:

1. “Would it be possible … to see a doctor”

Reply: It was not possible to recover enough information, by reviewing retrospectively the registry of the Otorhinolaryngology emergency department, in order to support strongly one of these two options. It would be very interesting to analyse patient’s views on this field. Most people, with a variety of disorders, attend hospitals in order to be reassured, diagnosed and treated; this fact could be indirectly related to the primary care use of the emergency department facilities. The hospitalisation rate was 5.2% and a percentage of 8.2 among all the cases did not meet medical criteria for an otorhinolaryngological diagnosis. Real emergencies that need an urgent or a highly specialized initial medical approach accounted for 13.8% of the whole. These findings, perhaps, suggest that most people attend hospitals in order to see a doctor. We think that research needs to clarify this situation.

2. Reviewer’s comment: “For instance an acute … not hospitalisation”

Reply: We agree with your point of view. We would like to add that the development of full-functioning primary healthcare services in combination with a reasonable ‘gate keeping’ and justifiable referrals, might modify the pattern of
the otorhinolaryngological disorders among the hospital visits, and offer effective ‘screening’ for the conditions which, really, deserve evaluation from a specialist.

3. Reviewer’s comment: “Also the number … interesting”

Reply: In 10% of the cases, consultations were performed within other specialities in the emergency department. For instance, consultations were performed within internal medicine specialists in 4.02% of the cases, paediatricians in 2.07%, neurologists in 1.28%, chest physicians in 0.68% and surgeons in 0.45%. Consultations, within dentists, accounted for 0.32% of the cases and for the rest of the cases (1.18%) within other specialities. [Special comment: We added this information in the Results section].

4. Reviewer’s comment: “Where are the patients …treated”

Reply: The patients with any kind of postoperative complication are seen directly in a ‘high surveillance’ ambulatory setting within the infrastructure of the Otorhinolaryngological Department. It is independent from the emergency department as facility and it could guarantee immediate access for the patients with postoperative problems. We did not include the patients with postoperative problems in our study, since they represent cases, which were not seen in the emergency department.

5. Reviewer’s comment: “The paper … have been used”

Reply: Diagnoses were also coded according to the International Classification of Diseases (ICD-10) in all cases with assured diagnosis through the clinical approach. We did not use the ICD-10 coding system for groups such as possible precancerous lesions and possible malignant neoplasms. In some cases the primary diagnostic grouping, used by the authors, was corresponding to more than
one ICD-10 code as shown in table 1. [Special comment: We added a reference currently numbered 5].

6. Reviewer’s comment: “Would it better … neck disorders”
   Reply: We have used otorhinolaryngological, head and neck disorders in the revised manuscript.

Major Compulsory Revisions

1. In Methods, ‘What does descriptive statistics mean?’
   Reply: A group of observations or a set of data forming a distribution can be summarised by using descriptive statistics. This branch of statistics describe aspects such as the location, the dispersion and the pattern of the distribution and use numerals, graphical descriptions (graphs) and tabular descriptions (tables). We suppose that your comment is related to the absence of a more detailed statement, in the previous manuscript, regarding the analysis of our data. [Special comment: For this reason we deleted the sentence ‘Data were analysed… statistics’ and we added a more detailed description of the analysis performed: ‘Statistical analysis of the data was performed with the package SPSS 13.0. Categorical variables such as sex, seasonality of visits, type of disorder and hospitalisation of the cases were described as counts (n) or proportions (%) while mean, standard deviation (SD) and median values were used for age (continuous variable). Graphical and tabular descriptions were also used to summarise data and present descriptive associations between different variables.’]

2. In Discussion, we have deleted the following sentences or statements as suggested:
• “One of the possible causes of nasal epistaxis in aged persons was partly due to the use of anticoagulant agents.”

• “The criterion used for distinguish benign paroxysmal positional vertigo was Dix-Hallpike manoeuvre.”

• “Regarding the top ten groups of disorders only dizziness, epistaxis and benign paroxysmal positional vertigo were related to older age groups (patients with median age between 57 and 58 years). The other seven of the ten most common groups were related to younger age groups (patients with median age between 18 and 34 years), [Table 2]. [Special comment: This statement was transferred to the Results section]. “Furthermore, acute tonsillitis and pharyngitis present their maximum frequency in the age group between 15 and 24 years, diffused or localized external otitis and acute sinusitis show their maximum frequency a decade later (age group 25 – 34). Acute otitis media and external ear canal obstruction by earwax are more common among children [Table 3]. Diagnosis of foreign bodies is more frequent in the paediatric subpopulation as well [6]. Dizziness, nasal epistaxis and benign paroxysmal positional vertigo show their maximum frequency in patients aged 65 years and over”. [Special comment: Deletion of the related reference previously numbered 6].

• “The rest of cases with dizziness (3.5%) are more possibly related to other peripheral or central vestibular causes without ignoring cardiovascular, metabolic endocrine and degenerative osteoarthritic causes [7]. Drug-induced or stress-induced ‘dizziness’ symptoms should be also considered [8]. [Special comment: Deletion of the related references previously numbered 7 and 8].

• “Crete is one of the 13 regions of Greece and at the same time the southernmost district of the European Union. It is the biggest island in Greece and the second
biggest (after Cyprus) of the East Mediterranean. It lies at the Southern Aegean Sea and at the crossroads of three continents Europe, Asia and Africa. Crete covers an area of 8.336 kms$^2$. According to the 2001 census the population of Crete reaches 603.000 inhabitants [4]. The island is divided in four prefectures, with that of Heraklion being the largest, with approximately 295.000 people. There are two public hospital units in the city of Heraklion of which one is the University General Hospital and the other is a secondary level hospital unit. The two hospitals are alternatively on duty every 24 hours, being the duty days for the University hospital approximately 183 per year." [Special comment: Part of this information was transferred to the Introduction section. Reference 4 renumbered as 3].

- “The aim of this study was to define the epidemiologic profile of the common head and neck conditions that patients complain of, with possible implications for health planning and General Practitioners’ training.”

- “This condition is more commonly related to anaphylaxis but, sometimes, it could be related to the use of Angiotensin converting enzyme inhibitors and rarely to Angiotensin II receptor antagonists, which are useful classes of antihypertensive agents”. [Special comment: Deletion of the related reference previously numbered 9].

- We have omitted table 3.

**Second Reviewer**

**Discretionary Revisions:**

We have omitted table 3 in agreement with your statement that some data presentation was found a little confusing.
Editorial changes requested:

1. **Language.**
   
   Reply: We made a minor language revision as suggested.

2. **Ethics.**
   
   Reply: “The present study conforms to the principles outlined in the Declaration of Helsinki. In our hospital, no ethical approval was necessary for this kind of retrospective study.”

3. **Acknowledgements:**
   
   Reply: “We would like to thank Dr Antoniou Katerina for her help in editing and technical details related to the revision of the manuscript. The study was not supported from a founding body or any other source. The department of Otorhinolaryngology and the department of Social Medicine contributed all the materials essential for the study.”