Author's response to reviews

Title: Prevalence of distressing symptoms in hospitalised patients on medical wards. A cross-sectional study.

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Version: 2 Date: 15 August 2008

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This letter contains our comments and describes the changes made to MS: 2013411684196382 ‘Prevalence of distressing symptoms in hospitalised patients on medical wards. A cross-sectional study.’ in response to the reviewers’ comments. We thank the reviewers for helpful suggestions.

**Version:** 1  **Date:** 20 June 2008  
**Reviewer:** Robin Fainsinger

**Discretionary Revisions**

1. *The rating of pain severity described in the methods is somewhat unusual. The most common cut points in the literature are mild pain 0-3/4; moderate 4/5-6/7; severe 7/8-10. The authors have referenced their choice, but an expanded rationale would be helpful.*

This way of presenting ESAS data for pain and other symptoms, grouping the patient scores into two groups (symptoms present: NRS ≥ 3, and symptoms present and severe: NRS ≥ 5), originates from the Edmonton Regional Palliative Care Program, where it was used in annual reports in the nineties. The same or similar presentations have been used in several articles presenting studies using the ESAS, as referenced. We have chosen this approach for three reasons: It is a convenient way to present a large and complex amount of data; it relates our data to the studies mentioned, and, importantly, it is in line with the Norwegian, national recommendations for NRS cut points in palliative care patients. A sentence explaining this has been added to the Methods section, and an additional reference has been given.

2. *Have made some suggestions for changes in the wording of the first paragraph in the results.*

3. *Suggest change the last sentence of the "Strengths & weaknesses"*

Changes have been made accordingly.

4. *In the discussion section "Comparison with other studies", the authors refer to 3 as the cut point for significant. As 0-4 is considered mild pain in many (? most) reports this is perhaps not as restrictive as the authors suggest. This may warrant more comment & explanation.*

We understand that the word significant is misleading and have changed the sentence to “cut-off point for symptom presence”. Using 3 as the cut point for symptom presence is more restrictive than in several other studies, which also include lower scores (NRS 1-2) in mild pain / other symptoms.

5. *In figure 1 would again suggest using the word "circumstances" rather than "chaos".*

This has been changed.
I gather that the main purpose of this research project and manuscript is to highlight palliative care needs of non-cancer patients on general hospital wards in Norway, with a goal to speak to local healthcare founders (who control the purse for service development and provision) and also to determine what kinds of differentiated services this hospital’s palliative care program needs to develop in the context of this particular hospital as a whole. This is a more interesting and novel aim than trying to describe what symptoms that palliative care patients experience – which has been done over and over again, with little difference from the information presented here.

Our aims have been stated in the abstract and in the Background section of the paper. Our main goal was to get an impression of the palliative care needs of a general Internal Medicine population. The first author is trained as an internist, and scoping the literature for reports on the prevalence of distressing symptoms in a general Medical population, the lack of reports made us come up with the idea of the present study. The majority of existing reports on symptoms in palliative care patients relate to cancer patients, and most of the studies have been performed in a palliative care setting. Studies in an unselected, general Medical population are scarce. However, we agree that an additional objective for the study was to gather background data for planning a palliative care service in our own hospital. Accordingly, this has been added at the end of the Background section.

Hence to reframe this study a bit towards the authors’ important and novel intentions, and to highlight the interesting data, I suggest the following:

1) Describe the whole population studied versus the palliative care population:
    
    a. Table 1 should have the whole population receiving ESAS (N=222) with columns breaking out and comparing the palliative and non-palliative groups, and included versus excluded patients; also, all tables should provide numbers and percentages, and the table should be realigned to help the reader understand main topic versus subtopics since it is currently hard to read.

    We have modified and expanded Table 1 to include the whole population, all the subgroups mentioned, and percentages. Hopefully a better layout has made the table easier to read, although more data is included.

    b. Compare symptoms between palliative and non-palliative patients. Figure 2 needs to be redrawn, and there are lots of ways to present this. Personally, I would like to know, for example, how does the proportion of folks who indicate “lack of wellbeing” differ between the population with palliative and non-palliative needs.

    Figure 2 has been redrawn as suggested, comparing the palliative and non-palliative groups.

2) Describe the problems in the context of cancer versus non-cancer illness:
    
    a. How do palliative cancer patients differ from non-cancer patients?
    
    c. How do non-palliative cancer patients differ from non-cancer patients?
Our reason for not doing this in the first place, was the small number of cancer patients included in the study (16 cancer patients in the palliative group and 11 in the non-palliative group), making the data less reliable. However, in response to this comment from the reviewer we have made the following changes:

We have included a paragraph on the results from the non-palliative group under the subheading All patients in the Results section. This paragraph also includes a sentence about the main differences between the cancer patients and the non-cancer patients in the non-palliative group. In addition, we have added two sentences in the last paragraph under the subheading The palliative patient subgroup, describing the main differences between the palliative and the non-palliative group, and between the cancer patients and the non-cancer patients within the palliative group.

d. Are there specific non-cancer subtypes that deserve special investigation (I presume heart disease and COPD based upon the prevalence numbers presented in the manuscript.)?

We have checked all the data once more, and a paragraph commenting on diagnoses and symptom profiles of diagnostic groups has been added under the All patients subheading in the Results section.

3) Describe how these findings are going to influence the growth of services in this Norway hospital, and what those implications are for other hospitals in Norway and abroad:

a. Do you need more palliative care providers experienced in non-cancer care?
b. What are the generalizability of these findings outside of the Internal Medicine services? Surgical services? Neurology? ICU?

These two points have been addressed through an addition to the Discussion.

c. Are you missing the wrong kinds of symptomatologists?
d. What are you missing in terms of understanding needs outside of symptoms (e.g. spiritual care), and is the anticipated to be different for palliative vs non-palliative or cancer vs non-cancer patients?

A paragraph addressing these points has been added to the Discussion.

Additional changes made:

The subheadings have been removed from the Discussion and changed in the Abstract to comply with the journal style.

We hope that we have addressed the reviewers’ comments in a satisfactory way and look forward to your response. We are happy to provide further clarification if needed.