Reviewer's report

Title: Automated comparison of last hospital main diagnosis and underlying cause of death ICD10 codes, France, 2008-2009

Version: 2 Date: 11 March 2014

Reviewer: Lee Taylor

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This manuscript addresses a topical issue and provides important evidence on the concordance of information on cause of death as reported on death certificates with information on main diagnosis provided on the record of the most recent hospitalisation prior to death. This information builds on the previous Swedish work and would be of interest to both researchers and government health agencies.

Major compulsory Revisions
In Appendix 3, it is noted that “….we checked whether UCD could have caused MD.” and “…the last question was whether UCD could have caused MD”. It is not clear whether this is carried out automatically by the Iris software or whether an additional process was developed by the investigators, or perhaps both. This should be clarified.

In Appendix 4 and the associated figure, reference is made to Parts and a variety of rules. Ideally these Parts and rules should be described and referenced in Appendix 4. However, if they are complex and not reproducible in the space allowed, then a reference should be included. If possible, this reference should be a web-link.

Minor Essential Revisions
In the attached document which shows the decision tree, box TC1 refers to “Partie 3”. I suspect this is meant to read “Part 3”.

Discretionary Revisions
Nil.

Level of interest: An article of importance in its field

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:
I declare that I have no competing interests.