Reviewer's report

Title: A Decision Aid for COPD patients considering inhaled steroid therapy: development and pilot testing

Version: 1 Date: 15 March 2007

Reviewer: Eric Bateman

Reviewer's report:

General
This is interesting innovative work. The paper describes the theory behind, development of a decision aid for patients who are being considered /are considering treatment with inhaled corticosteroids for COPD. Result from a small pilot study performed on 8 patients is included. Although largely descriptive, the more interesting and essential work is yet to come. Demonstrating its utility in a pragmatic controlled trial. I am more concerned about its uptake than its validity. It seems unlikely that more than a minority of patients with COPD will have the inclination, computer skills (the authors mention this concern, since most COPD patients are elderly, and may be unfamiliar with the use of the web for medical purposes)and patience to make use of the DA. This needs to be examined in some future study. However, as a concept this approach is sound. The authors do not provide very convincing motivation for a DA on this topic. One can think of other decisions that are more difficult and a better indication for developing a DA.

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Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)
The paper is well written, and I have no major problems with what is presented. Its main limitation is descriptive nature.

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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). My criticisms are not of the paper, but of the aid, which I viewed on the web. Firstly, there are several spelling errors e.g. budesonide (budenoside), iintiating, throat (thorat). Next, there is a picture of an adult with a spacer with facemask, which is not the preferred method. Most adults use and prefer mouthpieces. Perhaps both should be shown with a reason for the differences. This is misleading and is a missed learning opportunity for patients. The picture of thrush is extreme. This severity is hardly ever seen, and creates a fearful image for patients that is bound to affect their choice. The same applies to the bruising. The discussion lacks balance, as in most COPD patients bruises are contributed to by courses of oral corticosteroids and aging itself. Therefore the oversimplification that these are all due to ICS is misleading. The counterpoise involves the possible greater need for courses of OCS and the side-effects of these. Itch is mentioned often, but is a rare complication. See the Gronigen ICS questionnaire and papers using systematic questioning of patients receiving ICS. Itch scores lower than other symptoms. On another web page, in attempting to illustrate risk reduction (of exacerbations), the illustration is of a patient who might have 10 exacerbations over a period of time, having only 7 on ICS. Exacerbation rates per annum are much lower than this (1.1 or 1.2). Using these high numbers, which most COPD patients wont have in a "life-time" of COPD creates a false perspective of risk and benefit. These examples illustrate to me that although the intentions are good, attempts to educate have to ensure correct portrayal of the facts or the decisions remain ill-informed and no better than the paternalistic model of doctor deciding for the patient and pursuading them to take it regardless of their preference.

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Discretionary Revisions (which the author can choose to ignore)

What next?: Accept without revision

Level of interest: An article of importance in its field

Quality of written English: Acceptable

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.