Reviewer's report

**Title:** Early identification and secondary prevention of cardiovascular disease risk within a remote Australian Aboriginal primary health care service

**Version:** 1  **Date:** 13 September 2010

**Reviewer:** Mark Harris

**Reviewer's report:**

This is an important piece of research examining the impact of introducing CVD risk assessment introduced as part of the Aboriginal and Torres Strait Islander Adult Health Check (AHC) resulted in better identification of risk, improved delivery of preventive care and improved CVD risk. It has great implications for policy and practice in Australia and makes an important contribution to our understanding of the issues.

**Minor Essential Revisions**

The study has an interrupted time series design which is not ideal but addresses some of the difficulties in doing randomized controlled trials in Aboriginal communities. Generally the methodology is appropriate. However the authors have chosen to use 10 year coronary heart disease risk. The current NHMRC guidelines for Absolute risk recommend 5 year risk. The authors need to explain and justify their choice of 10 year risk. It may also be useful to present the data (both continuous % and categories) for 5 year risk so that it can be compared with other populations. It is little confusing because Table 1 has mean categories based on 5 year risk whereas table 4 uses 10 year risk.

In the results it would be useful to know the number and % of participants who were under 30, and who had various categories of risk at baseline and follow up in the tables. Figure 1 and text suggests that there were 58 included in the final analysis. This seems to be the denominator for Table 4. However Table 3 End of study seems to be based on a denominator of 63 (eg 43 patients had platelet lower drugs which was =68.3%).

It is interesting despite the very substantial increases in use of ACEi/ARBs and other antihypertensive drugs that there was only very modest decreases in blood pressure and cholesterol – the largest change was in HDL cholesterol (? Due to increased physical activity). It would be useful to have some discussion about this. Although reduction in number of cigarettes smoked has significant health benefits it will not contribute to calculated CVD risk because the Framingham algorithms only include smoking status.

The limitations of the study are well acknowledged and the implications for policy and practice discussed. The paper is well written.

**Level of interest:** An article of importance in its field
Quality of written English: Acceptable

Statistical review: Yes, and I have assessed the statistics in my report.

Declaration of competing interests:

I declare that I have no competing interests