Author's response to reviews

Title: Clinically Relevant Quality Measures for Risk Factor Control in Primary Care: a Retrospective Cohort Study

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Author's response to reviews: see over
Re: 2nd Revision of MS 2112595521121388 entitled “Clinically Relevant Quality Measures for Risk Factor Control in Primary Care: a Retrospective Cohort Study”

Dear Prof. Persell,

Thank you for your interest to publish our paper and the request of several minor changes that to be made. We carefully considered your comments and suggestions and made the necessary changes. We have addressed the comments in a revised manuscript and given a point-by-point response below. All modifications are outlined below and highlighted in the manuscript Word document.

We thank you for your comments and hope that these changes meet with your approval. Please direct further questions or comments to Nicolas Rodondi (nicolas.rodondi@insel.ch).

Sincerely,

Nicolas Rodondi, MD, MAS
Corresponding author, contact information above
Editor’s comment:

Your paper is of interest but there are several minor changes that should be made prior to publication.
The abstract still states that this is a better form of quality measurement. It is different but you have not proven it is better. Please modify the language to account for Dr. Bitton’s critique.

In accordance to your request, we have changed the abstract wording to the following (page 2, 1st paragraph):

“Evaluating whether physicians respond appropriately to poor risk factor control gives a different picture of quality of care.”

The discussion seems to imply that strict BP control increased mortality in some studies of hypertension but the cited reference is a meta-analysis that showed a non significant reduction in mortality and major events with tight control. This is misleading and should be changed.

We agree with the Reviewer and have corrected the discussion regarding this meta-analysis (ref 31, McBrien et al) on page 14, last paragraph:

“Second, for overtreatment, widely used guidelines at the time of data collection, such as the American Diabetes Association (ADA) or Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) [11,13] did not specify lower thresholds of blood pressure or HbA1c goals. Recent large studies have not shown significant mortality benefit among patients intensively treated for hypertension and diabetes mellitus [29-31], while one study reported increased mortality after intensive glucose lowering therapy in type 2 diabetes [32]. The ADA now mentions that less stringent treatment goals (HbA1c>7%) may be appropriate for adults with limited life expectancy or co-morbidities [13].”