Author's response to reviews

Title: Physicians' Ability to Predict the Risk of Coronary Heart Disease

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PDF covering letter
Dear Ms. Veitch,

Thank you for the opportunity to revise and resubmit our paper “Physicians’ Ability to Predict the Risk of Coronary Heart Disease” to BMC Health Services Research. As you will see below, we have noted the reviewers’ helpful suggestions and made appropriate changes to the manuscript. We have also checked the formatting of the manuscript for re-submission as you asked.

We hope that you will find the revised version of our manuscript suitable for publication. Please contact us with any questions or issues.

Sincerely,

Michael Pignone, MD, MPH
<table>
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<th>Reviewer comments</th>
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<td>1. In Table 1, column 3, there is an asterisk - what does it refer to?</td>
<td>The missing footnote should read: Risk of myocardial infarction, sudden death, or new-onset angina as calculated from the Framingham risk equations</td>
<td>Table 1</td>
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<td>2. Add text in Intro or Discussion about Montgomery- Br J Gen Practice. Do the authors think the use of real patients leads to systematically different results?</td>
<td>We have done so by adding a reference to the Montgomery paper in the Introduction and discussing it in the Discussion section. “Montgomery and colleagues evaluated the cardiovascular risk prediction ability of 69 general practitioners and 11 practice nurses in New Zealand. Providers were asked to estimate the risk of cardiovascular events for a series of older patients (ages 60-79) with hypertension who were being seen in the practice for a blood pressure check. Estimates were compared to the Framingham-calculated risk. Estimates were accurate in 21% of cases; 63% were underestimates and 16% overestimates. [montgomery 2000] The large number of underestimates stands in contrast to our study, and others [grover; friedmann] that mainly identified overestimation errors. This difference may result from the generally high risk of the patients included in the study by Montgomery and colleagues (60% had a 5 year risk greater than 15%). It is less likely, although plausible, that the use of real patients may produce systematically different results than the use of hypothetical vignettes.</td>
<td>p.13</td>
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<td>3. Could use of 5-year risk have influenced the results by causing confusion?</td>
<td>We have added this possibility to the limitations.</td>
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<td>4. Note that despite overestimation of risk, many patients go undertreated.</td>
<td>Our text on page 12 says: “efforts to improve the low utilization of statin drugs in high-risk patients cannot rely solely on educational efforts aimed at increasing the awareness of risk.” We believe that this statement adequately identifies the mis-match between risk perception and actual prescribing behavior and hence have not changed the text further.</td>
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Note: The second reviewer, Dr. Grover, did not suggest any revisions.