Author's response to reviews

Title: The Home-Heart Walk study: an intervention to promote physical activity and self-management in people with stable chronic heart failure - a randomised controlled trial

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Author’s response to reviews: see over
Dear Editors-in-Chief:

Thank you for your time and consideration of the manuscript “The-Home-Heart-Walk study: evaluation of an intervention to promote physical activity and self-management in people with stable chronic heart failure – an randomised control trial”.

I would also like to thank the reviewer for his constructive comments. The manuscript has been revised and the table on the following page provides a point-by-point response to the reviewer’s comments. Any changes made in the manuscript are kept in Track Changes for your review.

Thank you again for your time. I am looking forward to hear from you.

Kind regards

HuiYun Du
<table>
<thead>
<tr>
<th>Reviewer's comment</th>
<th>Response</th>
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<tbody>
<tr>
<td>1. Major Compulsory Revisions: Baseline measurements should be done before randomisation. It is bad methodology to do this afterwards as knowledge of assigned group (by patient or investigator) may affect performance. The abstract says that baseline data are collected after randomisation but the manuscript itself is unclear. This should be clarified and be made consistent. If at all possible at this stage, the protocol should be changed, if required, to ensure baseline measurements are made after consent but before randomisation.</td>
<td>Randomisation occurs after the collection of baseline data. Manuscript has been modified to clarify the consent, baseline assessment, randomization sequence.</td>
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<td>2. The study is totally underpowered to observe effects on morbidity and mortality. The study will ‘fail’ on these outcomes, which could be used by some to suggest that the intervention is ineffective. This needs to be highlighted.</td>
<td>We are aware that the study is underpowered to show effects on morbidity and mortality. We are collecting this data as part of monitoring adverse events. The manuscript has been revised accordingly.</td>
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<td>3. Minor Essential Revisions: Brief power-calculations on the primary endpoint and number of participants should be given in the abstract.</td>
<td>Information regarding power-calculations and sample size has been added into abstract.</td>
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<td>4. Please state that tables 2/3 that these apply to intervention and control groups.</td>
<td>This has been clarified in Table caption and in-text.</td>
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<td>5. Discretionary Revisions: The logic of using both SF-36 and Minnesota scales should be explained.</td>
<td>Using both measures allow us to pinpoint the effect specifically related to chronic heart failure (MLWHF), at the same time overall general wellbeing (SF-36). The SF-36 will also allow comparison of study results with populations other than chronic heart failure.</td>
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<td>Physical function domain can be extracted from each. What is the power to show a difference on the Minnesota Physical domain?</td>
<td>5 points difference in total score of MLWHF with estimated standard error of 6-7 points is considered as a meaningful minimum difference. (Rector, et al., 1995) Based on a previous heart failure study, 105 people would have 95% power to detect 5 point difference in the MLWHF score. Although information on a meaningful minimum difference specifically on physical function domain of the MLWHF is not available, it is generally accepted that 10% of total score of a measurement is the meaningful minimum difference. It is assumed a sample of 166 is sufficient to detect 10 points difference in physical function domain of MLWHF.</td>
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