Author’s response to reviews

Title: A population-based screening study for cardiovascular diseases and diabetes in Danish postmenopausal women: Acceptability and prevalence

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Response to Jeremy Oats, reviewer I:

Comment: The healthy nature of the Danish population in lack of obesity troubles extrapolation.

Response:

The healthy nature of the Danish population in lack of obesity does, indeed, to some degree make extrapolation of our results difficult, and, as you say caution, must be taken. Nevertheless, a similar healthy state of the general population (10-16% with BMI>30) is to be found in the rest of Scandinavia, counting Norway, Sweden and Finland. Scandinavia accounts for approximately 25 million people, some being elderly women, to whom the results may be generalized.

Revised: Thank you; this is a very good point. We have added to the discussion that "it is very likely that our study findings cannot be fully extended to other races and populations with other risk factor profiles such as a higher proportion of obese people, for example" (Limitaion section, line 341-343, page 14).

Response to Angela Maas, reviewer 2:
Comment 1: What was the reason for lower participation among the eldest group of women and did you ask them again?

Response: This is an excellent point. Alongside this study, we made an interview study among 10 women who declined the screening invitation. The interviewed women were selected from the four age groups invited for screening. Our findings showed that the main theme voiced by non-attendees was finding the screening offer "personally irrelevant". This perception was rooted in personal health-related assessment, knowledge and previous experiences with the healthcare system. After having received supplementary information about the screening programme and its purpose during the interview, the non-attendees appeared to view the relevance of being screened differently. However, it would be interesting to explore non-attendance among the eldest further, especially as you mention - because they seem to have the highest risk.

In the "the screening programme" section (line 130 to 132, page 6), it is outlined that "women who did not attend their screening programme booking and had not declined the invitation were re-invited once".

Revised: The following change has been made to the manuscript in the discussion section (line 255 to 259, page 11): "Alongside the screening programme, we have interviewed 10 non-attendees to explore reasons for non-attendance. Finding the screening offer personally irrelevant was revealed as the main theme for non-attendance. This perception was, however, found to be changeable especially by newfound awareness of the screening programme and the potential benefits of attending."

Comment 2: It could have been useful to include family history and hypertensive pregnancy disorders as important risk factors. Why not use them to discriminate among women?

Response: A very good point. In the study, we accounted for family predisposition to stoke, myocardial infarction, diabetes, hypertension, PAD and AAA. Unfortunately, we did not seek information on hypertensive pregnancy disorders. Information on medical history was collected based on a self-reported questionnaire. However, self-reported information on hypertensive pregnancy would probably have been associated with high recall bias due to the time span between pregnancy and screening.

Revised: In Table 1 (line 511, page 22), family predisposition has been added and in the Table note we have added the following " Family predisposition was defined as mother, father, sister or brother (line 514, page 22)."
Changes in Table 1 and 2: In Table 1 "Characteristics of the study population" (page 22) includes age, smoking status, comorbidity and predisposition. In the previous manuscript Table 1 also included screening results related to BMI, cholesterol, HbA1c, systolic blood pressure and diastolic blood pressure these findings are moved to Table 2. As Table 2 outlines findings of disease prevalences in the screening programme (page 22-23).

Comment 3: Do you consider primary preventions to be core tasks for GP´s?

Response: In Denmark, GPs do not have the possibility and facilities to make screening examinations to the extent that was done in this study. But collaboration with GPs is essential for achieving adherence towards recommended prophylactic interventions. Therefore, the CPs were informed of the screening results including initiated preventive interventions.

Revised: No changes made