**Author’s response to reviews**

**Title:** Warfarin anticoagulation in Hemodialysis Patients with Atrial Fibrillation: Comparison of Nephrologist-led and Anticoagulation clinic-led Management

**Authors:**

Hamad Bahbahani (dr.hamad_bahbahani@hotmail.com)

Ahmed AlTurki (ahmedalturkimd@gmail.com)

Ahmed Dawas (ahmeddawas@gmail.com)

Mark Lipman (mark.lipman@mcgill.ca)

**Version:** 1  **Date:** 09 Nov 2017

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Dear Dr Frank Van der Sande

Editor BMC Nephrology

Thank you for granting us a provisional acceptance to publish our study “Warfarin anticoagulation in Hemodialysis Patients with Atrial Fibrillation: Comparison of Nephrologist-led and Anticoagulation clinic-led Management” in the BMC Nephrology. We have reviewed the 2 comments that were raised by the reviewers. In this letter we are describing how we addressed those points.

In terms of the cost effectiveness analysis that was raised by the first reviewer, we have just finished the analysis and we added a description of it in the last paragraphs of the Method section (line 19, page 6) and in the Results section (line 20, page 8). The analysis was based on laboratory and professional fees specific to the Province of Quebec, Canada, which vary somewhat among Canadian provinces and more so across other countries.

The laboratory cost of INR assay is 0.50 CAD$ / test and the professional fee for warfarin management is 12.50 CAD$ / test. The latter is payable only to the anti-coagulation clinic physician and not to the nephrologist.

The average annual number of INR tests was 60 in Institution A (nephrologist-led management) and 26 in Institution B (anti-coagulation clinic-led management). Therefore, the average annual cost of INR testing per patient in Institution A is about 30 CAD$ / patient, compared to 338 CAD$ / patient in Institution B. Therefore, there is significant overall costs savings associated with nephrologist-led management despite the more frequent INR testing.
Regarding the point raised the second reviewer about the frequency of INR measurements and warfarin adjustments. The mean frequency of INR testing in each institution was one of our predefined end points, and we reported a mean frequency of 1 test every 6.0 days in Institution A (nephrologist-led management) in comparison to 1 test every 13.9 days in Institution B (anticoagulation clinic-led management). This was described in the last sentence of the first paragraph in the TTR Analysis section of the Results. We felt that this was the preferred way to report this end point because our cohort contained patients with variable duration of warfarin therapy. In terms of frequency of warfarin adjustments, these data were not well documented in a large proportion of our patients’ charts. Therefore, we did not report it.

I hope this information helps clarify the points raised during the review

Hamad Bahbahani, Ahmed Alturki, Mark L. Lipman