Author’s response to reviews

Title: Quality assessment of clinical practice guidelines for chronic kidney disease: a systematic review

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Author’s response to reviews:

Dr. Hayley Henderson
Editor-in-Chief
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Dear Dr. Henderson:

I have reviewed each of the reviewer's comments and suggestions. Below are my replies to each of the mentioned points.

I'm sending the manuscript with modification in track change and tables highlighting.
I look forward to your prompt response to continue the process.

Best regards.

Jorge Coronado

Dear Carole Ayab, I profoundly appreciate the time you have put into revising my study and your valuable comments and suggestions. Below are my replies to your feedback:

1. Methods: It's unclear line 24-26 page 5: "or languages that were feasible to translate": which language? French for example?

I’m referring to languages easy to translate for the authors. In this study, we translated the Holland and Italian guideline because one of the authors is from Netherlands and other knew Italian. I’ll edit the text to the following:

3) published in English, Spanish or languages that were feasible to translate for the authors.

2. But, how authors considered non applicable item? Some AGREE II items may not be applicable to the particular CPGs under review. AGREE II does not include a "Not Applicable" response item in its scale. So there are different strategies to manage these items and the decision should be made in advance and described.

I modified the text to the following: Each item was assessed using a 7-point scale (from 1 “strongly disagree” to 7 “strongly agree”), even if they were not applicable.

3. One question: line 19, p17: is the sentence right: "The CPG from the USA (?) is not recommended (?) …"? in table 2, the CPG from USA is Recommended.
In this paragraph we were describing what guidelines from the ones classified as recommended guidelines (table 2) could work to be adapted in other countries with low incomes; the USA guideline wasn’t recommended for this purpose. For more clarity, the sentence will be amended to the following:

These results allow the recommendation of the CPGs developed in Malaysia, Australia, Scotland and the United Kingdom (NICE guideline) to support other developer groups to create their own CPGs or adapt them to their context. For this last purpose, the CPG from the USA is not recommended due to a low and very low score on the stakeholder involvement and applicability domains, respectively.

4. References: Ref26 line 36 p28: "guideline implementation tolos ==> tools.

Amended: (reference number changed due to an adjustment to comply with one of the comments made by the other reviewer)


All changes to the text can be seen in the manuscript with modification in track change.

Best regards.

Jorge Coronado
Dear Robert J Walker, I deeply appreciate the time you have invested on revising my study as well as your valuable comments and suggestions. Below are my replies to your feedback:

1. There are statistical tests that I am unable to assess and recommend seeking additional advice (please specify which tests these are in the ‘Comments to Editor’ box):

   Descriptive statistic was applied to analyze the guidelines in both an individual and group manner. For each guideline, the standardized score for each domain and the total average of the domains were expressed as a percentage. When considering the guidelines as a group, each domain was expressed as a mean±standard deviation. The domains were compared using Student's t-tests for independent samples (the test was two-tailed, and statistical significance was considered for P-values of less than 0.05).

   The paragraph on data analysis will be amended to this:

   Descriptive statistics were applied to analyse every domain (percentage; mean and standard deviation; median and interquartile range)….. The overall mean of each of the CPGs domains were compared using Student's t-tests for independent samples (the test was two-tailed, and statistical significance was considered for P-values of less than 0.05),……

2. Some guidelines websites were accessed and reviewed but the CARI guidelines website was not accessed or referenced. See comments below. I am not clear how the authors derived the stakeholder involvement. For example with the CARI guidelines they have only listed the summary reference (reference 21) they have not actually gone to the CARI website www.cari.org.au where there is very detailed information as to how the guidelines are developed, involvement of nephrologists, nurses, dietitians, and patient groups.

   The CARI guidelines were accessed through the website, as well as the manual for the development of guidelines. The CARI guideline was RECOMMENDED and as observed in table 2, all domains are above 60%. I agree with the reviewer, we shouldn’t have put down the reference of the guideline’s summary, instead we should have write down the access to the website. Therefore, the right reference is:
3. The KHA-CARI is a joint group with representation from Kidney Health Australia (Consumer organisation) and the Australian and New Zealand Society of Nephrology as well as input from the Renal Society of Australasia representing the clinical side. Also the guidelines are for Australia and New Zealand not just Australia, please correct this. (Australasia represents both countries). So the CARI guidelines were developed by both the guidelines group under the auspices of ANZSN and KHA and they report back to ANZSN.

I have replaced Australia with Australasia in both the text and tables.

4. Whilst it is very important to compare the different guidelines, to me as a reviewer and reader of the article, the repeated comparisons of statistical variation between the guidelines do not really add any useful information over and above your classification of high, moderate or low. Also with each comparison, there is just a number which is not linked to a specific guideline or guidelines. It is very difficult to follow logically which guidelines are being referred to with each comparison. For example CPGs assessment according to recommendation - last paragraph on page 11. "The average score of the CPGs recommended for use in clinical practice was significantly higher than those recommended with modifications" does not really add a lot of extra helpful information.

In the comparison between subgroup we decided to make a description of the main statistical findings in order to avoid making a table with the statistical findings per each subgroup. Following the comments above and in order to simplify, we have proceeded to exclude text that doesn’t affect the core of the results.

5. Likewise the discussion is excessively long and repeats a lot of what has been covered in the results. I would recommend a very much shortened and pithy discussion, highlighting the positives of the high ranked guidelines and why. From a clinical perspective and use for the clinician reading this manuscript, who is looking for the best guidelines to follow, this what they would be looking for.
The objective of the study was to determine the quality of the guidelines included and evaluate if there were differences in the quality according to the place of development, type of development group, etc. Due to this, the discussion is focused on the findings of each domains, the possible causes for lower quality in some of the guidelines and what is being proposed nowadays to overcome these difficulties. Following your comments above, we have proceeded to exclude some points that don’t affect the core of the discussion and we have organized the discussion with subtitles for more clarity.

All changes to the text can be seen in the manuscript with modification in track change.

Best regards.

Jorge Coronado