Author’s response to reviews

Title: Health care use, drug treatment and comorbidity in patients with schizophrenia or non-affective psychosis in Sweden: A cross-sectional study.

Authors:

Erica Brostedt (Erica.Brostedt@sll.se)
Mussie Msghina (Mussie.Msghina@sll.se)
Marie Persson (Marie.Persson@sll.se)
Björn Wettermark (Bjorn.Wettermark@sll.se)

Version: 1 Date: 03 Aug 2017

Author’s response to reviews:

Response to Reviewer 1, Nobutaka Ayani, M.D.

Comment #1

The manuscript contain a number of unnatural sentences that need correction (English language editing).

Response: The manuscript has now undergone English language editing by a native speaking American scientist.

Comment #2

It is unclear why you focused on the comparison of the schizophrenia patient group with the NPA patient group, and how do you think the severity or treatability of the NAP patients compared with the schizophrenia patients.

How do you think healthcare provider should manage provide treatment to the NAP patients? You should describe the clinical implications for the treatment to the NAP patients.

Response:

As we state in the introduction part (Background section, page 5, lines 98-103), previous studies had often studied schizophrenia patients together with other non-affective psychosis patients. Comparing the two as separate population as we do in the present study would help facilitate comparison with those earlier studies where both patient groups are studied as one population.
We have now added a paragraph (Background section, page 5, lines 103-107), where we outline the difference in the treatment of schizophrenia and other non-affective psychosis.

Comment #3

In the paragraph of "Prevalence by age and gender" in Results section, median age for the NAP patients was 50 (P.6, line 146), whereas the median age was 48 in Table 1. You should correct this inconsistency.

Response:

Median age for the NAP patients is now corrected to 48 and the difference in median age between the two patient groups is corrected to 5 (Results section, page 7, line 162).

Comment #4

In Table 1, you should add a quartile range to "Age (median)".

Response:

Quartile range is added to “Age median” in Table 1 (Results section, page 7, line 165) for both patient groups.

Comment #5

In Table 2, sum of percentages of Psychiatric care and No Psychiatric care is over 100%. You should correct this inconsistency.

Response:

In Table 2, (Results section, page 9), the inconsistent percentage of “No Psychiatric care” for the schizophrenia patient group has been corrected. Additionally, the incorrect RR and 95%CI for “Primary care” has been corrected.

Response to Reviewer 2, Sangeeta Dey, FRANZCP.

Comment # 1
However, it is not entirely clear how specific psychiatric comorbidity, like self-harm behaviour, is included. Are there any reasons why depressive disorders or anxiety disorders are not identified as significant in addition to substance abuse/dependance?

Response:

In the present study we focused on somatic co-morbidities that are known to be risk factors for increased mortality; (obesity (E65-66), hypertension (I10-I15), diabetes type 2 (E11), substance abuse/dependence (F10-19)). Self-harm (X60-84) was included as an indicator of suicidal and para-suicidal behavior. This is now stated in the Methods section in lines 137-141, page 6 and in the Discussion section in lines 274-276, page 13. A new reference is also added in support of this (reference 27), which can be found in lines 442-443-391, page 18, References section.

Comment # 2

Tables : suggestion is to use tables for significant findings only and the rest could be summarised in the text.

Response:

We appreciate your suggestion but we believe it is valuable for the readers to have access to all data and to discuss the significant ones in the text instead.

Comment # 3

Any comment(s) about the rate of olanzapine use even though recent guidelines (NICE, PORT, RANZCP guidelines for schizophrenia) are not encouraging it due to risk of metabolic syndrome.

Response:

We have now added a short discussion on why this may be (Discussion section, page 12, lines 253-255). We believe this is probably due to the fact that olanzapine is often used in the emergency settings during the acute phase of treatment because of its calming and sedating effects and its lack of acute extrapyramidal side-effects and also that patients have continued with this medication even during the stabilization and maintenance phases of treatment, where it would have been advantageous to switch to medication with little or no metabolic side-effects.
Comment # 4

Recommend shortening of discussion section.

Response:

The discussion part has been shortened and part of it moved to the background section (from Discussion section, page 13, lines 235-237 and lines 239-248 to Background section, page 3, lines 62-65 and lines 66-75).

Additional changes (not commented by reviewers):

In Table 3 (Results section, pages 10) we have added RR and 95% CI for all substances and routes of distribution.

Renumbering of references have been undertaken as a consequence of editorial decisions regarding exclusions and additions of references.