Author’s response to reviews

Title: MEETING INDIVIDUALIZED GLYCEMIC TARGETS IN PRIMARY CARE PATIENTS WITH TYPE 2 DIABETES IN SPAIN

Authors:
Miñambres Inka (iminambres@santpau.cat)
Jose Javier Mediavilla (jmediavillab@semergen.es)
Jordi Sarroca (jsarroca@almirall.com)
Antonio Pérez (aperez@santpau.cat)

Version: 1 Date: 24 Dec 2015

Author’s response to reviews:

dear editor,

we are pleased to resubmit form publication the revised version of the article entitled "MEETING INDIVIDUALIZED GLYCEMIC TARGETS IN PRIMARY CARE PATIENTS WITH TYPE 2 DIABETES IN SPAIN" (BEND-D-15-00083) we appreciated the constructive criticisms of the editor and the reviewers and hope this new version of the manuscript is improved and can be now accepted for publication.

kind regards,
inka miñambres, antonio perez

we have addressed each of the reviewers comments and requests as outlined below.

reviewer #1:

background: the article is easy to read and easy to understand.

sometimes, the references are given in different format (round and square brackets). this should be corrected.

we thank very much the reviewer for his appreciation. we have checked the manuscript in order to have all the references formatted accordingly.
In the introduction the authors discuss the background of reaching glycemic targets, which is adequate, but I somehow miss the potential of disease management in this sector.

There is work from Germany showing how a different management of care pathways also helps achieving glycemic targets and this potential should be highlighted to elaborate a complete picture of strategies.

The reviewer’s comment is really interesting. In Spain there doesn’t exist an integrated pathway of care for type 2 diabetic patients, and this fact may have contributed to differences found between the different studies. This relevant aspect is now commented on the discussion section.

Material and Methods:

The authors report about assigning the patient into three different strategies. I do not fully understand how the assignment was performed and how the adherence to the strategy was controlled. It would be important to highlight this. Maybe this was presented in the referenced publications, but it is important to highlight it again, because it will directly reflect the quality of adhering to the standards and this will affect concordant evaluation.

The assignment of patients into the three different strategies was performed by the investigators according to patient characteristics recorded in the clinical visit and as described in the “study design” section and table 1. The present investigation intends to analyze the distribution of the population into glycemic targets, not to evaluate how professionals implement the targets throughout time. So, the study design does not allow to evaluate the adherence to the strategies.

I understand that the different strategies were assessed in the same population, but I do not understand why there are more patients in the HYPO group. This should be explained.

We completely understand the question raised by the reviewer. In order to implement each classification strategy, all items necessary to classify a single patient to a determined category had to be present. Discordant numbers, reflect missing items that did not allow us to classify that patient. As the hypo strategy uses different items for patient classification compared with the SED or ADA/EASD strategies, the number of missing patients therefore is discordant. We have included a brief commentary in the new version of the manuscript.

Discussion:

In general I agree, but I miss the evaluation of the potential of the different strategies. Does this different strategy make sense or not? What would be the long-term potential
outcome of using the different strategies? I would like it a lot if the authors could speculate on this and, finally, the authors should give a recommendation whether this strategy should be part of chronic care management and improved innovative disease management strategies as highlighted previously [1].

As the reviewer suggests, it would be very interesting knowing about the potential of the different strategies of classification in terms of improving patient outcomes. However, this information is still lacking and no strategy has shown better outcomes than the other. That’s why we conclude our work pointing: “Long-term studies are needed to determine if the new strategy recommendations will lead to a reduction of diabetic complications and hypoglycemia in patients with diabetes”. We have, however, added a comment on the limitations of current strategies for glycemic targets individualization, and the importance of clinical judgment in this scenario.

Thank you very much for having the chance to review this article. I recommend publication after my comments are addressed.

Sincerely yours.

Reviewer #2:

BACKGROUND: is well written.

METHODOLOGY:

The authors have assigned patients in three groups with totally different strategies. On what basis these patients were assigned in these groups. please specify.

The information requested by the reviewer is addressed in table 1. As specified, all patients have been classified into 2-3 categories according three different strategies of classification. The were chosen on the basis of being the most widely accepted and used ones I SPAIN (SED and ADA/EASD) or being simple (HYPO).

How was hypoglycemia assessed and how was it classified as high or low risk.

As specified in study design, only hypoglycemia that required medical assistance during the 12 months prior to the study visit was included in the study. We agree that more accurate ways of assessing hypoglycemia do exist, however, as our study is retrospective including only the hypoglycemic episodes that needed medical assistance (which can be confirmed by clinical charts) seemed much more reliable. Classification of hypoglycemia risk into low and high risk categories is specified in table 1.