Author’s response to reviews

Title: Clinical Characteristics and Outcomes of the Oldest Old people with Type 2 Diabetes - Thailand's perspective from a tertiary diabetes center in Thailand

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Author’s response to reviews:

Thank you very much for valuable comments in my manuscript “Clinical Characteristics and Outcomes of the Oldest Old people with Type 2 Diabetes - Thailand's perspective”. I edited it as suggested and highlighted edited part in red color font in newly uploaded files.

Please kindly see this edited manuscript. For detailed responses to the comments, please kindly see the followings

Response to Reviewer #1:

1. In Table 1, kindly mention the no. of times/year for frequency of A1C testings in brackets as units. Also in foot note mention how the data's were presented.
We edited it as suggested in Table 1.

2. The subjects had lower levels of LDL cholesterol, were they taking anti hyper lipidemia drugs. Similarly how many of them were on anti hypertensive drugs?

We edited it as suggested. Eighty-two percent of patients were on anti-hypertensive drugs and 76.7% of patients were taking statins at the time of study.

3. Can the authors explain why there was female predominance in the study subjects?

The possible explanation would be the relatively longevity of female diabetic patients when compared with male patients. Also, female predominance in Thai diabetic patients (from National Health Survey) and tended to be more actively participate in seeking medical care when compared with male diabetic patients.

References:


4. Diabetic Neuropathy was one of the important microvascular complications, especially among elders and with long duration of diabetes. Why was neuropathy assessment left out?
We acknowledged that diabetic neuropathy was one of important chronic diabetic complications but it also had very variable prevalence depends on the sensitivity of assessment tools. In our cohort, there had incomplete data in the screening of diabetic neuropathy for more than half of patients so we accepted our limitation in discussion part. Prospective study for these patients in the future would have included this complication as one of important microvascular complications.

5. In Table 2: Such a detailed distribution of treatment patterns is not necessary for this paper. Hence this table can be removed and the side headings alone (Diet control, OHA, Insulin and OHA) can be added along with the variables in Table 1.

We edited it as suggested in Table1.

6. In Figure 1, for long standing DM, some graphic patterns can be drawn inside the bar.

We tried to edit it but as suggested from reviewer2, it would be better to split the bar to compare statistically between long-standing and elderly-onset subgroup.

7. Kindly mention the percentage and number of patients above the bars in Figure 2 & 3.

We edited it as suggested in Figure1.

Response to Reviewer #2:

1. The title of the article is "Clinical Characteristics and Outcomes of the Oldest Old people with Type 2 Diabetes - Thailand's perspective"; whereas the study is done in one tertiary care diabetes centre. Hence the word "Thailand's perspective" is misleading and should be corrected to reflect that it is a hospital based study.
2. It is mentioned that all the data were retrieved from the medical records of these patients. It could be more informative to provide the levels of other biochemical parameters like fasting blood glucose, total cholesterol, HDL-cholesterol, HOMA-IR etc.

Thanks for suggestion but we did not have comprehensive laboratory tests to calculate HOMA-IR as this lab did not include in our routine practice. For others parameters, many patients had random or postprandial plasma glucose so we decided to represent only A1C as a target for glycemic control. For lipid profiles, some patients checked only LDL and many patients checked lipid panels in postprandial state for convenience. Therefore, we decided to present only LDL in Table1.

3. Table 1: details of some of the important co-morbidities of diabetes like diabetic nephropathy and diabetic neuropathy could be provided, if the data is available.

We acknowledged that diabetic neuropathy was one of important chronic diabetic complications but it also had very variable prevalence depends on the sensitivity of assessment tools. In our cohort, there had incomplete data in the screening of diabetic neuropathy for more than half of patients so we accepted our limitation in discussion part. Prospective study for these patients in the future would have included this complication as one of important microvascular complications.

4. Figure 1: Appropriate statistical tests should be done to compare if the glycemic control of the elderly diabetics were better compared to the long standing diabetic group.

We edited it as suggested in Figure1.
5. Mixed split insulin is associated with the highest incidence of hypoglycemia in the elderly diabetes group. The reasons why this treatment could lead to hypoglycemia should be discussed in the discussion section.

We edited it as suggested: Mixed split insulin regimen was associated with the highest incidence of hypoglycemia. This finding might come from variable eating patterns of some elderly patients. In those patients, a basal-plus or basal-bolus regimen might be better options in patients who failed basal insulin regimen.

6. Table1 shows that a higher number of elderly diabetes subjects had Charlson Comorbidity Index in the moderate and severe range. However, elderly diabetes subjects demonstrate a better glycemic control compared to the long standing diabetes group (Figure 1). These findings should be discussed.

We edited it as suggested: Even though almost 80% of elderly-onset diabetic patients in our cohort had moderate to severe comorbidity conditions, their glycemic control were relatively better when compared with long-standing diabetic patients. The possible reasons might be explained by the benign nature of new-onset diabetes in elderly [5] and also various comorbidity conditions especially chronic kidney diseases in these patients might make patients more aware of eating habits.

7. Other sub-analyses like the association of the risk factor with the occurrence of co-morbidities and/or Charlson Comorbidity Index could add more value to the study.

Thanks for suggestion but we had limited retrieved data from medical records so we represented only importance findings of comorbidity as showed in Table1.

8. Line 11: "referring to people age 85 or older" should be changed to" referring to people aged 85 or older". The whole manuscript can be thoroughly proof-read to avoid minor grammatical errors.
We edited it as suggested.

Thank you again for these valuable comments. We hope to share our data in real practice to your prestigious journal soon.

Best Regards,

YOTSAPON THEWJITCHAROEN, M.D.