Reviewer’s report

Title: Clinical and economic outcomes of remotely delivered cognitive behaviour therapy versus treatment as usual for repeat unscheduled care users with severe health anxiety: a multi-centre randomised controlled trial

Version: 0 Date: 19 Oct 2018

Reviewer: Christopher Dowrick

Reviewer's report:

The authors conducted a multicentre RCT of remote cognitive behavioural therapy (RCBT) versus treatment as usual for patients with health anxiety who made frequent unscheduled contacts with health care providers in primary and general health care settings. The rationale for the study is clearly set in its research and policy context. The parameters for service setting, and for patient characteristics and recruitment, are specified and justified, as are the primary and secondary outcomes, the details of the intervention (including supervision and quality control measures), and the procedures for statistical and health economic analysis. There is good evidence of PPI involvement in study design, especially in relation to how the trial was presented to potential participants. The findings are in general presented clearly. There is a balanced discussion of the strengths and limitations of the study, leading to the reasonable conclusion that RCBT should be considered a clinically and cost-effective intervention for frequent health care users with health anxiety.

The manuscript could be strengthened as follows:

1. The presentation of the qualitative arm of the study, in both methods and results, is too brief to be useful in its current form. It should either be expanded or removed from this manuscript; I suggest the latter, given that a further paper on this is planned.

2. The requirement of only 2 unscheduled appointments in 12 months does appear low, as the authors note, and some justification of this would be helpful. While it has the benefits of simplicity and inclusivity, it also has potential disadvantages, principally that it tends to over-represents younger women who are in general more likely to attend more frequently: see Dowrick CF, et al Br J Gen Pract. 2000; 50:361-5.

3. Patient recruitment and follow-up were both problematic, but (as the authors note in the discussion) this is not untypical of studies involving this particularly complex and vulnerable group of patients. It would be helpful to flesh out in the text the reasons for drop out at recruitment stage, as noted in Figure 1; e.g. is there information on why 163 people declined...
to participate, or 135 were uncontactable?. Regarding follow-up, it is apparent and understandable that a concerted effort was made by the research team to achieve maximal follow-up (72%) at the primary end point of 6 months; however the discussion of study limitations should include acknowledgement of much lower rates at the other three time points, and possible implications of this.

4. The suggestion that results may be sustainable (page 17) is not based on direct evidence so would be better removed.

5. There is a typo in the abstract, Results paragraph: '12 with months'.

Are the methods appropriate and well described?
If not, please specify what is required in your comments to the authors.

Yes

Does the work include the necessary controls?
If not, please specify which controls are required in your comments to the authors.

Yes

Are the conclusions drawn adequately supported by the data shown?
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Yes

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