Reviewer's report

Title: Cross-cultural adaptation and validation of Spanish version of The Foot and Ankle Ability Measures (FAAM-Sp)

Version: 1 Date: 23 Jun 2017

Reviewer: Mwidimi Ndosi

Reviewer's report:
Thank you for the opportunity to review this study again which aimed at adapting and validating the Foot and Ankle Ability Measure (FAAM) into Spanish.

My key concerns raised in the first review have been only partially addressed and I have added these in the discussion section of my comments.

In this review, I have focused again on the methodology quality and the presentation of the results rather than language inaccuracies. I believe the authors may benefit from having their manuscripts language edited before submitting the revised version. I have reviewed all sections from the abstract to the tables and figures and made suggestions for change as appropriate.

Abstract

Background

When used for the first time PRO should be written in full
The aim of this study was to cross-culturally adapt the FAAM into Spanish and… - you are not adapting the Spanish version.

Methods

When written for the first time IPSOR should be written in full
The sentence beginning with 'Confirmatory factor analysis …' needs to be reworded as confirmatory factor analysis (CFA) was not assessed and it is an assessment itself

Results

The first sentence '…with a mean age was 38.86 …' replace 'was' with 'of'

Conclusion

Is the FAAM-Sp valid for the Spanish-speaking patients outside Spain?

Main document

Introduction

If the authors want to incorporate the information on evidence-based practice in this section, it would be helpful to give a current definition of evidence-based practice and show how this relates to evaluating health -related quality of life. In the current section, I do not see the relationship between evidence-based practice and evaluating health-related quality of life and it may even read better if they started this section with line 3: 'The Foot and Ankle Ability Measure (FAAM) is a …'

Does PRO stand for 'patient related outcome' or 'patient-reported outcome' measure or 'patient-reported outcome questionnaire'? It is important for the reader to see the difference between an outcome and an outcome measure.

Methods
Page 4 line 56, please supply the reference for ISIS guidelines
Results
To help the reader follow the results easily and logically, the authors may want to consider changing the order of presenting the results and change some subheadings, thus: (i) Cross-cultural adaptation, (ii) construct validity, (iii) internal consistency, (iv) convergent validity and (v) test re-test validity.

Cross-cultural adaptation

In the translation and adaptation section of the results, the authors could report the results of the readability tests.

Figure 1. Consider changing 'direct translation' to 'Forward translation (English to Spanish)'

Construct validity

Table 1. Based on the aims of this study, I do not see the reason for categorising all patient characteristics by gender.

If there is a reason for testing differences between patient subgroups (hypothesis driven test), the authors may want to specify the test statistic (and degrees of freedom) before the p-values.

In page 8 line 24, the authors mention that the characteristics of the sample are presented in Table 1. If these tests were carried out with a hypothesis in mind, then key results should be reported within the text i.e. whether the differences between groups do/not exist. Where there are more than two groups being tested (e.g. professional status, educational level, pain location), then the authors should also indicate where the difference lies.

In table 1, under professional status, the term 'active' can be confusing to readers. If appropriate, the authors could amend this to 'employed' or 'employed + self-employed'. Please clarify and amend
On the same table (Table 1), is the 'VAS scale of QoL' the same as EQ5D VAS? Please specify the name of the scale to avoid confusing the readers.

On all table, could the authors replace the comma (,) with a full stop (.) for a decimal point?

Since the number of item in the FAAM-ADL has been reduced from 21 to 15; to make it clearer and avoiding confusing the readers, the authors could consider amending the titles of tables 2 to 4 thus:

- Table 2. Initial factor matrix for the 21-item ADL FAAM-Sp
- Table 3. Item-item correlations matrix for the 15-item FAAM ADL-Sp
- Table 4: Inter-item correlation for each factor of the 15-item ADL FAMM-Sp

In Figure 2, the readers would want to know what F1, F2 and F3 in the ADL subscale represent. This information can be found hidden somewhere in the discussion and the authors could add a legend at the bottom of the figure to specify this, or they consider adding a label against each of the three item groups.

Criterion-related validity

Since the authors have assessed only convergent (not divergent) validity, this could be reflected in the above sub-heading (change to convergent validity). For this test, the authors have correlated the FAAM-ADL and FAAM-Sports subscales with the EQ5D. It is important to specify whether it was the EQ5D descriptive or EQ5D VAS that was used in these analyses.

Test re-test validity

This information is combined in with the construct validity and internal consistency but it would be clearer for the reader if this was reported separately.
Discussion
The new information added in page 10 line 1-18 presents the results which should not be in this discussion section. Since table 1 now has the list of diagnoses which indicate a clinical heterogeneity, I was expecting the authors to discuss if this has any implication for the use of the tool in different patient populations. Do they advise caution when using the tool for patients that were not well represented in their sample? Do they recommend this tool to be used as a generic quality of life tool?

While the FAAM-Sp has been shown to be valid and reliable, the results (especially of those of the FAAM-ADL which has 15 items - reduced from 21) suggest that FAAM-Sp may have different measurement properties from the original FAAM or other versions of the FAAM. Given that the group of patients is highly heterogeneous with a small number for each sub-group, and selection bias cannot be ruled out, are the authors going to be more cautious in their conclusion?

Level of interest
Please indicate how interesting you found the manuscript:
An article of importance in its field

Quality of written English
Please indicate the quality of language in the manuscript:
Acceptable

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