

AUTHORS' REPLY

Dear Sir,

We agree with Dr Afifi that the subject matter is of importance and we appreciate his extensive comments. He has suggested that we could improve our analysis by: (1) comparing the group of patients having diabetes mellitus and/or hypertension with others; and (2) classifying the patients into four groups and analysing the data accordingly.⁽¹⁾ However, the aim of the study was to assess the adequacy of overall cardiovascular disease preventive care in general practice through a medical audit, and our presentation was mainly directed to this overall aspect.⁽²⁾

As a matter of interest, we separated out patients with hypertension, diabetes mellitus and hyperlipidaemia (814 patients) from the rest with other acute and chronic conditions (others = 531). The results, as expected, showed better cardiovascular preventive care (see Table below).

Criteria	Patients with HT, DM, HL (n = 814)	Patients with other conditions (n = 531)
	No. (%) achieving criteria	No. (%) achieving criteria
Height	521 (64.0)	169 (31.8)
Weight	662 (81.3)	255 (48.0)
Smoking status	407 (50.0)	135 (25.4)
BP recording	802 (98.5)	460 (86.6)
Blood sugar screening	702 (86.2)	250 (47.1)
Lipid profile	624 (76.7)	220 (41.4)
p-value < 0.01		

HT: hypertension; DM: diabetes mellitus; HL: hyperlipidaemia

The reason for displaying acute versus chronic illnesses was to indicate that for cardiovascular preventive care, the GPs should go beyond just hypertension / diabetes mellitus / hyperlipidaemia, and preventive care should include patients irrespective of whether they present with acute or chronic conditions, as prevention is the cornerstone of primary care.

Also, this was a retrospective study looking into existing medical records. It is indeed possible to categorise the 1,345 patients into the categories as suggested in point (2) above, but because of "missing" data, no useful analysis can be done. For example, the smoking status in many patients was not recorded. To a lesser extent, data pertaining to the rest of the categories may not be recorded as well. A prospective study with specific instructions to do and record all the categories above would need to be done, but then it will not be a medical audit.

In Table III of our report,⁽²⁾ the achieved outcome indicators were only for patients with hypertension and diabetes mellitus on follow-up in the past year. This was clearly stated in Table I. We audited the control of hypertension in hypertensive patients (n = 558) and control of diabetes mellitus on diabetic patients (n = 234). We see no relevance to the comment that "adding normoglycaemic and/or normotensive subjects to the general pool of patients definitely diluted these percentages, and hence the reader would expect a lower level of control for the diabetics and hypertensive patients". It was also not our aim to identify the percentage of newly-diagnosed diabetics and hypertensives, and these patients were actually excluded from the audit as they had not been followed-up for the past one year, as we would have needed time to control their blood pressure and the blood sugar.

The author of the letter stated that there seemed to be a discrepancy between what was stated in the Discussion and what was stated at the end of the Results. The confusion arose because a sentence was omitted (see italics below) in the Results section. It should read as follows:

"Overall, the clinics achieved the target standard set in three of the ten criteria... in hypertensive patients. *For smoking status, there was a significant difference between male and female patients being asked about their smoking status (males 51%, females 32%, p < 0.01).* There was no significant difference between patients' gender, ethnicity and age and all the other criteria assessed."

Please note that the above published sentence read “*all the other* criteria assessed”, and not, *all* the criteria assessed, indicating there was an exception, which was the gender difference in asking the smoking status. This significant difference was again mentioned and discussed further in the Discussion section. The sentence was inadvertently deleted in one of the draft revisions prior to submission. It was not noticed by the authors during the proofreading as it appeared also in the Discussion section. We apologise for the error and thank Dr Afifi for pointing this out.

It should also be noted that blood taken for lipid profile from the GP clinics was sent to the laboratory, which tested for total serum cholesterol, HDL-cholesterol and LDL-cholesterol (calculated) and the triglycerides. We should have mentioned this in the Methods section. Finally, with regard to the comment on our discussion “to the previous similar audits without comparison of those results with the current studies”, we stated that the performance between the clinics varied widely, which was also found in the two audits we referred to (published in a peer-reviewed indexed journal). We mentioned it because all three studies were done in Malaysian GP clinics, which showed wide differences in their performance. However, there can be no further comparison of results as the topic (cardiovascular disease preventive care) is different from the other audits (care of diabetic and hypertensive patients).

Yours sincerely,

Chan Sook Ching
Lee Tong Weng
Teoh Long Chee
Zaid Chelvaraj Abdullah
Gnanasegeran Xavier
Sim Cho Keng
Ng Aik Chiew
Ian Ong Chye Heng
Rathmathunisia Begum
Leong Chui Chui

Royal College of Medicine Perak
Department of Primary Care
Universiti Kuala Lumpur
3 Jalan Greentown
Ipoh 30450
Malaysia
Email: csching@rcmp.unikl.edu.my

REFERENCES

1. Afifi M. Audit on cardiovascular disease preventive care in general practice. Singapore Med J 2008; 49:956-7.
2. Chan SC, Lee TW, Teoh LC, et al. Audit on cardiovascular disease preventive care in general practice. Singapore Med J 2008; 49:311-5.