



SDI Review Form 1.6

Journal Name:	British Journal of Medicine and Medical Research
Manuscript Number:	Ms_BJMMR_24673
Title of the Manuscript:	A comparison of rheumatoid arthritis patients in Kuwait with other populations: results from the KRRD registry
Type of the Article	Original Research Article

General guideline for Peer Review process:

This journal's peer review policy states that **NO** manuscript should be rejected only on the basis of '**lack of Novelty**', provided the manuscript is scientifically robust and technically sound.

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PART 1: Review Comments

	Reviewer's comment	Author's comment (if agreed with reviewer, correct the manuscript and highlight that part in the manuscript. It is mandatory that authors should write his/her feedback here)
<u>Compulsory</u> REVISION comments	<p>Kindly rewrite the abstract as there are so many grammatical mistakes. In abstract, objective section is missing.</p> <p>From where KRRD was taken and did author has taken any official permission for study and publication from KRRD authorities, if yes then kindly mention it.</p> <p>As the prevalence of RA patients in Kuwait is 1%, what is the prevalence of RA patients in your study?</p> <p>"Yet, descriptive data on RA patients in Kuwait, like the rest of The Middle East, is scarce." Do author have any reference for this statement, if yes then kindly mention it.</p> <p>ACR criteria for RA registered, kindly explain this criteria or provide reference for this criteria</p>	<p>The MS has been sent to an English grammar specialist and the grammar has been reviewed and corrected. Objective section was added in abstract.</p> <p>KRRD is a registry for RA across the major hospitals in Kuwait. The founder of KRRD is the first and the corresponding author for this MS. Co-authors of this MS are members of KRRD. In other words, members of KRRD are the ones who are writing this MS.</p> <p>The data in this MS are extracted from a registry. All patients in the registry have RA so assessing prevalence of RA in our study is not possible.</p> <p>Reference added.</p> <p>Reference added.</p>



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	<p>“They were recruited from the rheumatology departments of four out of the six major government hospitals in Kuwait.” As this is multi centric study, did author have taken human ethical permission from this 4 government hospitals. Why 2 hospitals were left?</p> <p>As there were many investigators, there may be chance of variability while data collection, how author have overcome this issue?</p> <p>How RA patients from registry of UK, Germany, Switzerland, and USA were involved and compared?</p>	<p>In Kuwait we have one medical research committee that covers the whole country. It includes members from the Faculty of Medicine and members who represent all the hospitals. The committee is chaired by the undersecretary of the Ministry of Health. Once the approval is taken from this committee then the research can be conducted in all the Government hospitals.</p> <p>Two hospitals were left because the rheumatologists in those hospitals did not have the interest in contributing in this registry. However, as it is mentioned in this MS, this should not have affected the quality of this study as the 4 included hospitals are from different governorates in Kuwait and they well represent the diversity of the Kuwaiti population.</p> <p>This point was considered when the registry was first established. Therefore, regular meetings have been conducted among the team and several courses have been arranged to check on their techniques. In addition, the chief investigator in each centre takes random cases, after they have been entered, and makes sure that the data were collected and entered correctly.</p> <p>International registries and large studies were</p>
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	<p>What were the other appropriate statistical procedures which were selected according to guidelines? What are those guidelines?</p> <p>Did author have used trial version of SPSS software? or original one used</p> <p>Mean \pmSD were mentioned in this study, did this data are normally distributed?</p>	<p>carefully reviewed. The following features were considered as possible in choosing the study:</p> <ul style="list-style-type: none"> - Multicentre. - Includes a large number of patients. - Population-based. - Study population not selected (e.g. certain age group or certain gender or on a certain drug) - Large cohort study. - With regard to serology, the same lab. technique has to be used for the selected serology test. <p>The appropriate statistical procedures that were used in the MS were selected according to the “guidelines for statistical analysis and data presentation”. E.g. Chi square test is used to compare categorical variables...etc. These guidelines are available in the following references: Morgan GA, Griego OV, Gloeckner GW. SPSS for windows: an introduction to use and interpretation in research. Harvard: Mahwah NJ, Erlbaum L Associates; 2001.</p> <p>Clark LA, Watson D. Constructing validity: basic issues in objective scale development. Psychological assessment 1995;7:309-19.</p> <p>Original SPSS software was used.</p> <p>By using One-Sample Kolmogorov-Smirnov Test,</p>
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		<p>all the p-values of testing the normality of study variables were below the significant level 0.05, and that indicates that the variables are not normally distributed. And because our sample size is large, the t-test is valid for large samples from non-normal distributions. Accordingly, it is assumed that the sample is normally distributed and t-test is justified to be used. References to support this are: https://statistics.laerd.com/spss-tutorials/testing-for-normality-using-spss-statistics.php http://stats.stackexchange.com/questions/9573/t-test-for-non-normal-when-n50</p>
	<p>How many female patients were anaemic?</p>	<p>Evaluation for anaemia was not considered in the protocol of this study and was not retrieved from the registry.</p>
	<p>Why data was missed out of 835 in table 1 and study?</p>	<p>As investigators, we try our best to get the data completed. However, it sometimes gets difficult to get all data available for all patients especially for the serological tests as sometimes the results get delayed and do not arrive on time.</p>
	<p>Why RF factor and ACPA were compared and how (2×2 contingency table) P=0.001 was calculated?</p>	<p>We thought it will be interesting to know how many of the RA patients in Kuwait have a combination of RF and ACPA whether positive or negative. Also to assess if the correlation between RF and ACPA is similar to other RA populations. For 2×2 contingency table, a significant influence</p>



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	<p>In table 3, along with percentage, kindly provide exact number of RA patients.</p> <p>In table 5, smoking is mentioned under co-morbidities? However, why alcoholic patients were excluded?</p> <p>What is the difference between RA patients from</p>	<p>between RF and ACPA was tested using chi-square test of contingency. The following path was applied in SPSS:</p> <p>Analyze > Descriptive Statistics > Crosstabs</p> <ul style="list-style-type: none"> • Select “RF” as the Row variable, and “ACPA” as the Column variable • I clicked on the Statistics button and I select Chi-square in the top LH corner and Continue. • I clicked on the Cells button and select Column percentages (or Row) and Continue. • Click OK <p>Reference: https://statistics.laerd.com/spss-tutorials/chi-square-test-for-association-using-spss-statistics.php</p> <p>Numbers added on table as requested.</p> <p>We wanted to compare smoking between our RA population, the Kuwait general population and other RA population so to make it easy it was decided to include it in this table along with the co-morbidities. Kuwait is a conservative country and alcohol consumption is forbidden. It is rare to find people who drink alcohol in Kuwait. In addition, people who drink alcohol are not being honest when they are asked about it because it is against the law so this piece of information will not be reliable if included.</p> <p>Kuwait general population includes the whole</p>
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	<p>KRRD and Kuwait general population?</p> <p>Kindly define other population with which RA patients of KRRD were compared?</p> <p>In this study, co-morbidities were compared with COMORA study and QUEST-RA study. Why other co-morbidities were compared with QUEST-RA study (cardiovascular disease in patients with RA)? On what basis this comparison was done?</p> <p>“Yet, descriptive data on RA patients in Kuwait, like the rest of The Middle East, is scarce.” As authors have claimed that there is a scarcity of data on RA</p>	<p>population of Kuwait. KRRD includes only RA patients. KRRD patients were recruited from major hospitals in Kuwait.</p> <ul style="list-style-type: none"> - The Swedish Biologics Register. - International, cross-sectional study (COMORA). - The Norfolk Arthritis Register (NOAR). - QUEST-RA Group. - The British Society for Rheumatology Biologics Register. - The ERAN cohort. - The Multi-registry National Data Bank for rheumatic diseases, Kansas, USA. - The Consortium of Rheumatology Researchers of North America (CORRONA) Registry. <p>It depends on the factor being studied. As mentioned earlier, when citing a study for a comparison, we try to match other factors such as age, gender, the methodology used to measure this factor..etc to have a fair comparison as possible. Accordingly, the reference can be different according to the factor studied.</p> <p>The few references that were cited in table-5 were</p>
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	<p>patients in Kuwait, even though Kuwait general population data with reference is already presented in table 5.</p> <p>In discussion, 2nd paragraph, due to genetic heritability, high family history of RA were found. In your study 17.1% RA patients had family history of RA. Kindly compare your finding with other studies, genetic factors would be the reason but it doesn't reflect from your study.</p> <p>Smoking habit in KRRD was 9.2% while in Kuwait general population with RA was 17.95%. Smoking habit in same country varies with different studies, kindly discuss?</p> <p>RA patients with hypertension and hyperlipidemia were less from KRRD as compare to Kuwait general population, due to young age this may have found in your study. Discuss this with respect to various age groups.</p>	<p>on Kuwait general population and NOT on RA patients in Kuwait.</p> <p>In table-4, a comparison has been made in family history between our RA population and other populations (17.1% vs 10.2%). Genetic study is beyond the scope of this research but of course can be done in a separate paper in the future as it is a very interesting point as you have suggested.</p> <p>Smoking among RA PATIENTS is less than in the GENERAL POPULATION in Kuwait. This can be explained by many reasons. Joint pin and deformities could be one of them. Patients education by their rheumatologist could be another explanation.</p> <p>We did consider this factor when the cited studies were selected. So both age and gender distribution in the cited studies were comparable to our study.</p>
<u>Minor</u> REVISION comments		
<u>Optional/General</u> comments	<p>Manuscript need to be corrected grammatically. Kindly discuss only finding of your study. Check method and results of your study rewrites it systematically. Include relevant literature in Introduction section. Avoid excessive references.</p>	<p>Your advice has been well taken. The MS has been sent to an English grammar specialist and the grammar has been reviewed and corrected. We tried to limit the number of references but the objective of the study is to compare our findings with other studies so having multiple and variant studies was essential to the study and could not be further minimized.</p>