PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Access to rheumatologists among patients with newly diagnosed rheumatoid arthritis in a Canadian universal public health care system
AUTHORS	Widdifield, Jessica; Paterson, J. Michael; Bernatsky, Sasha; Tu, Karen; Thorne, J Carter; Ivers, Noah; Butt, Debra; Jaakkimainen, R. Liisa; Gunraj, Nadia; Ahluwalia, Vandana; Bombardier, Claire

VERSION 1 - REVIEW

REVIEWER	J.A.B. van Nies Leiden University Medical Center, The Netherlands
REVIEW RETURNED	17-Oct-2013

GENERAL COMMENTS	This is a interesting paper with a clear research question and I feel that all the issues are adressed well. This is a interesting paper to read. You've clearly defined your research question and used a very large sample size. The paper is clearly written. A small comment to the second part of your discussion were you state that it is unknown how long patients have symptoms before seeking medical care (which is true for your cohort). However, you could refer to the following paper, stating that patient delay in another setting (the Netherlands) relatively small. (van der Linden MP. et al (Long-term impact of delay in assessment of patients with early arthritis, A&R 2010 Dec;62(12):3537-46). In this paper the patient delay in early arthritis as well as RA patients is described. The patient delay is very small relatively to the GP-delay.

REVIEWER	van der Helm van Mil Leiden University Medical Center The netherlands
REVIEW RETURNED	26-Oct-2013

GENERAL COMMENTS	This is a relevant, well balanced study. I have no comments

REVIEWER	Theodore PiIncus Clinical Professor of Medicine, NYU, USA
REVIEW RETURNED	11-Dec-2013

GENERAL COMMENTS	This manuscript presents sophisticated and encouraging analyses concerning the earlier treatment of rheumatoid arthritis in Canada. One matter that the authors may consider involves their concern that there is no change in the 3-month referral pattern. That may reflect in (large) part recognition by many general practitioners (and some in the rheumatology community) that many people with symptoms and signs suggestive of early RA experience spontaneous remission from these symptoms. Such data are seen in older epidemiologic, population-based studies from the United States, in which only about 25% of patients who met criteria for RA in a population experienced signs or symptoms of disease 3 to 5 years later (1;2). More recent data from a large early arthritis clinic indicated that 60% of patients had self-limited symptoms (3). Therefore, particularly as there is a shortage of rheumatologists essentially everywhere, and there is strong evidence that a delay of 3 months is not deleterious, in general, to the likelihood of a good response or remission (4), that the absence of improvement in the 3-month delay may not be nearly as deleterious as the Authors may imply. Of course, the Authors are free to disagree with this interpretation. Another matter that may be of interest is that the Authors have made relatively extensive efforts to see if the diagnosis is correct, but haven't commented on how often it was incorrect. The reviewer has the impression that the diagnosis of RA in the hands of general practitioners is more frequently incorrect than is generally recognized, but it is difficult to get data concerning this matter, and this could be within their data to also present. A few minor comments: Page 2: On the third line of RESULTS, perhaps "overtime" is not a single word. On third-to-last line of RESULTS, perhaps insert "patient" before socioeconomic status. Page 3: again, "overtime" may really be two words here; perhaps say "we studied only" rather than "we only studied" Page 5: The Authors comment on a validated case definition but, as noted, the possibility of studying how frequently the diagnosis may be incorrect would possibly be an interesting additional contribution. Page 9: the Authors say "within 3 months a more favorable benchmark" – but the reviewer places a caution on this. Again, the comment that "results appear encouraging" – 41% of patients are still not seen within 3 months. As noted, the reviewer might not consider this as discouraging as the Authors infer. Reference List (1) Mikkelsen WM, Dodge H. A four year follow-up of suspected rheumatoid arthritis: the Tecumseh, Michigan, community health study. Arthritis Rheum 1969; 12:87-91. (2) O'Sullivan JB, Cathcart ES. The prevalence of rheumatoid arthritis: follow-up evaluation of the effect of criteria on rates in

	Sudbury, Massachusetts. Ann Intern Med 1972; 76:573-7. (3) Visser H, le Cessie S, Vos K, Breedveld FC, and Hazes JMW How to Diagnose Rheumatoid Arthritis Early: A Prediction Model for Persistent (Erosive) Arthritis, Arthritis Rheum 2002, 46: 357–365 (4) Puolakka K, Kautiainen H, Mottonen T, Hannonen P, Korpela M, Julkunen H, et al, for the FIN-RACo Trial Group. Impact of initial aggressive drug treatment with a combination of disease-modifying antirheumatic drugs on the development of work disability in early rheumatoid arthritis: a five-year randomized followup trial. Arthritis Rheum 2004;50:55–62.

VERSION 1 – AUTHOR RESPONSE

We have made some minor revisions based on the feedback from reviewers.
For Reviewer #1: We have addressed her comment and referenced the indicated paper on Page 9: "While a previous study reported that the patient delay is very small relative to the family physician delay[31], in our study, it is unknown how long patients have symptoms before seeking medical care, or remain in primary care before their RA is recognized."
For Reviewer #3: We have address his comments on Page 10: "Conversely, we are also unaware of the disease activity and functional status of the subgroup of patients who do not receive timely rheumatology care within three months. Recent data from a large early arthritis clinic indicated that 60% of patients had self-limited symptoms.[32] Therefore, a delay of three months in receipt of rheumatology care may not always be as deleterious to the likelihood of a good response or remission.[33]"