

Review Form 1.6

Journal Name:	Cardiology and Angiology: An International Journal
Manuscript Number:	Ms_CA_79024
Title of the Manuscript:	Effect of cigarette smoking on location of infarction in patients presented with ST-segment elevation myocardial infarction
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. To know the complete guideline for Peer Review process, reviewers are requested to visit this link:

(<https://www.journalca.com/index.php/CA/editorial-policy>)

Review Form 1.6

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)
Compulsory REVISION comments	<p>I am a medical statistician who is not medically qualified, but with considerable experience in conducting analysis of epidemiological studies.</p> <p>There are a considerable number of weaknesses with this paper which need sorting out before the paper can even approach being publishable.</p> <p>The main problem is that clear differences between the two groups have been identified in Table 1 in both age and particularly sex, but no attempt has been made to adjust comparisons between smokers and non-smokers for age and sex. To do so is absolutely necessary, otherwise one cannot tell whether differences seen between the two groups relate to smoking or to sex or age. The current analyses are all of little value, without such adjustment.</p> <p>The final conclusion that “smokers experience coronary artery disease at a younger age than non-smokers” cannot validly be drawn without taking account of the age distribution of smokers and non-smokers in the population at large. The study would have been better designed if comparison were made between the distribution of smoking in the infarction patients and the distribution in either a representative sample of the population at large or a sample of patients with diseases not believed to be thought related to smoking.</p> <p>It is stated that all the patients were recruited from the cardiology department in Tanta university hospitals, but it is not stated how. Were they consecutive patients starting at some time point, and there just happened to be 50 smokers and 50 non-smokers – or how was equality of numbers in the two groups achieved?</p> <p>For the data collected on factors such as smoking, diabetes, hypertension and past history and family history of CAD was all the data collected from the patient at the time, or was information also obtained from hospital notes, relatives or friends? I note that there seems to have been no missing data whatsoever, which seems surprising. Did all patients really know about family history of CAD, for example – or did “no” include “non known”?</p> <p>What happened to patients who arrived at hospital with an infarction who died before they could be interviewed?</p> <p>The terms “smokers” and “non-smokers” are ambiguous and should be clearly defined. Some researchers refer to “smokers” as those who are currently smoking while others refer to “smokers” as those who have ever smoked. Please clarify which. Was any minimum requirement needed for number smoked?</p> <p>Care should be taken that in the text (separately for the abstract) of the paper itself, abbreviations are always defined, that they are defined the first time the full text version is used, and that subsequently the full version is not used, but only the abbreviation.</p> <p>In the abstract, I note for example that the abbreviations STEM1 and MI are defined in the first two sentences of the background section, but the full text versions rather than the abbreviations appear subsequently in the abstract in various places. EF is referred to in the results section, but is undefined.</p> <p>In the main text, I note that in the introduction both the abbreviations STEM1 and MI are defined twice for no good reason, and that various abbreviations are undefined the first time they are used (e.g. PCI and CABG in the second sentence of “patients and methods”).</p> <p>In Tables 2 to 4 it would be better to give the terms in full to help the reader, or if only the abbreviation is used in the main body to remind the reader what all the abbreviations mean in the footnote, not just some of them as for TCP, ATCP and SOB in Table 3.</p> <p>It seems to me that there is no actual need to refer to group 1 and group 2 at all. Just referring to them as smokers and non-smokers seems adequate.</p> <p>The text describing the contents of the tables is needlessly repetitive of the results in the Tables. Thus, for example, in relation to the results presented in Table 1, one might simply say “As shown in Table 1, smokers compared to non-smokers were significantly younger and more likely to be male”, and for Table 2 say “Smokers were significantly less often hypertensive than non-smokers, but no significant differences were seen in diabetes mellitus</p>	

Review Form 1.6

	<p>or in family history of coronary artery diseases (Table 2)".</p> <p>Some of the English is poor. For example in the first paragraph of the abstract the sentence starting STEM1 might better read "The hospital mortality rate is greater for STEM1 than for acute coronary syndromes". I considered going through the paper suggesting improvements to the text, but I would rather do that when the analyses have been revised to adjust for age and sex, as this may well change the text.</p> <p>I am not quite sure why bits of the text under "Patients and Methods" are in bold type. They would be better in normal type.</p> <p>I will not comment in detail on the literature referred to in the discussion as I am not familiar with it. However, I do note that discussion sections typically include mention of the strength and weaknesses of the study conducted by the present authors, and no such mention is included here.</p> <p>The Tables could be better laid out. Thus in Tables 2, 4 and 5 it is sufficient to have numbers and percentages just for presence of the condition. Thus one could have a table laid out as follows for Table 2.</p> <table border="1" data-bbox="893 661 1958 892"> <thead> <tr> <th rowspan="2">Risk factor</th> <th colspan="2">Number of cases</th> <th rowspan="2">χ^2</th> <th rowspan="2">p</th> </tr> <tr> <th>Smokers</th> <th>Non-smokers</th> </tr> </thead> <tbody> <tr> <td>Hypertension (HTN)</td> <td>18 (36.0%)</td> <td>28 (56.0%)</td> <td>1.03</td> <td>0.0</td> </tr> <tr> <td>Diabetes mellitus (DM)</td> <td>13 (26.0%)</td> <td>22 (44.0%)</td> <td>3.56</td> <td>0.0</td> </tr> <tr> <td>Family history of coronary artery disease (FHx)</td> <td>7 (14.0%)</td> <td>13 (26.0%)</td> <td>2.25</td> <td>0.1</td> </tr> </tbody> </table> <p>* Statistically significant at p<0.05 Though the χ^2 and p values should be adjusted for age and sex.</p>	Risk factor	Number of cases		χ^2	p	Smokers	Non-smokers	Hypertension (HTN)	18 (36.0%)	28 (56.0%)	1.03	0.0	Diabetes mellitus (DM)	13 (26.0%)	22 (44.0%)	3.56	0.0	Family history of coronary artery disease (FHx)	7 (14.0%)	13 (26.0%)	2.25	0.1	
Risk factor	Number of cases		χ^2	p																				
	Smokers	Non-smokers																						
Hypertension (HTN)	18 (36.0%)	28 (56.0%)	1.03	0.0																				
Diabetes mellitus (DM)	13 (26.0%)	22 (44.0%)	3.56	0.0																				
Family history of coronary artery disease (FHx)	7 (14.0%)	13 (26.0%)	2.25	0.1																				
Minor REVISION comments																								
Optional/General comments																								

PART 2:

	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)
Are there ethical issues in this manuscript?	<i>(If yes, Kindly please write down the ethical issues here in details)</i>	

Reviewer Details:

Name:	Peter Lee
Department, University & Country	UK