also much higher than in other causes of ESRD (Table 2). This does not need much explanation as we are sure that the writer agrees that diabetics suffer from increased mortality due to micro- and macrovascular complications.

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Risk factors for hypertension in UAE

Sir

I have read with great interest the article by Sabri and colleagues [1] in the Eastern Mediterranean health journal and I appreciate the authors’ work. However, I would like to make few comments because of the importance of hypertension and its risk or associated factors.

The authors mention in their abstract as well as in the results and discussion sections that hypertension among cases was high in low-income participants. Looking at the bivariate analysis (Table 1) and the multivariate analysis (Table 4), we would see the reverse. Table 4 shows that those with higher income (income equal 5000 dirhams or above) were 2.69 times more likely to be hypertensive than others.

The authors contradict themselves again where they show that the crude odds ratios for obese participants (BMI ≥ 30 kg/m²), those with no physical activity, and those with positive family history of diabetes were 0.46, 0.72 and 0.28 respectively (Tables 1 and 2). This suggests these factors are protective against hypertension, whereas in Table 4 the adjusted odds ratios for the previously mentioned variables are 4.29, 1.8 and 2.58 respectively, suggesting that obesity, sedentary lifestyle and family history of diabetes are risk factors for hypertension.

The cause behind such contradiction is the order of rows in the Tables 2 and 3 from which the odds ratios were calculated in the bivariate analysis. The correct order is to put the exposed or the risk factor in the first row and the non-exposed in the next [2,3]. If the rows are reordered in the bivariate analysis tables, the correct odds ratios for variables studied are obtained and these would be 1/existing figure.

The authors mention in the sampling section that cases and controls were age, sex and nationality matched. They say that they recruited 500 hypertensive patients, 64 did not participate and thus 436 cases and 436 matched controls were included in the final analysis. From Table 1 the number of cases and controls varied markedly in sex, age group and slightly in nationality. The prob-
The problem here is that hypertensive patients under 40 years were more reluctant to participate in the study in comparison to those aged 50 years and above where cases outnumbered controls. Could this raise the question of selection bias? Al-Shahi et al. [4] investigated the differences between consenters and non-consenters in demographic and clinical features at first presentation and outcome during follow up. They found differences between adults who consent to participate in observational record-based research and those who do not or cannot. Accordingly, they recommended that further research should be directed towards exploring consent bias in other disease groups and other research designs to see if the bias is pervasive and remains unpredictable.

As regards the study tools, it is slightly ambiguous whether the authors used a self-reported questionnaire or a structured interview. Did the authors use a self-reported questionnaire to be filled by literate participants and resort to a structured interview for illiterate participants?

Finally, drawing the conclusion that “more expatriates than UAE nationals had hypertension is in keeping with previous findings of a Swedish study” (page 618), is flawed [5]. First, the difference in the Emirate study was not significant even in bivariate analysis (Table 1). Moreover, the Swedish study adjusted the foreign-born individuals for sociodemographic and lifestyle factors, which was not done in the Emirate study.

References


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