Authors' response

Dr. Afifi has raised some important points concerning our study [1]. We used a matched case-control design [2–4]. The method we employed was the one that adjusted for age, sex and nationality [5]. It is true that the association of risk factors may vary by age, sex and nationality, which are mostly fixed factors, but so long as the sample is adjusted equally among the cases and controls with sufficient sample size, the results will carry significant weight. In this regard, it should be noted that the differences between hypertensives and normotensives in terms of sex, age and nationality were not significant ($P < 0.154$, $P < 0.598$ and $P < 0.964$ respectively). The difference between males and females with regard to the age group was also not significant ($P < 0.210$). Furthermore, we do not think that there was a bias in patient selection because of the consent issue. The main reason for exclusion of subjects from the study was the presence of other chronic diseases rather than them not consenting to participate.

Regarding the questionnaire versus interview, questionnaires were used for those who could read and write, while the same questions were asked using a semi-structured interview format for illiterate subjects.

We agree the contradiction between the table and the text deserves clarification. Table 1 shows that 34.1% of the low income group had hypertension while only 25.1% of the control group had hypertension, indicating an association between low income and hypertension. Similarly, 41.4% of those in the obese group (BMI ≥ 30 kg/m²) were hypertensives as compared to 25.1% of the non-obese group, suggesting an association between higher BMI and hypertension. In Table 3, the percentage of hypertensive subjects with positive family history of diabetes (19.6%) was significantly higher than the percentage (6.3%) of normotensive subjects with positive family history of diabetes. We believe that the confusion arose due to the fact that the direction of association was not clearly indicated in Table 4 while describing the odds ratio. While the different groupings are given in brackets, we failed to indicate which of the different subgroups the odds ratios referred to. The associations in Table 4 as follows: Odds of having hypertension for obese subjects was 4.29 times when compared to those subjects with BMI < 30 kg/m²; the odds of having hypertension for the low-income group (< 5000 dirhams) was 2.69 times higher than the other group (5000+ dirhams); the odds of having hypertension for subjects with positive family history of diabetes was 2.58 times higher than the subjects with negative family history of diabetes; the odds of having hypertension in those who reported physical inactivity was 1.8 times higher than those who reported being physically active; and those with more than 3 children were 1.67 times at higher risk of having hypertension as compared to those with fewer than 3 children. Thus, there are no contradictions as such in the results.

References


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