

PEER REVIEW HISTORY

BMJ Open publishes all reviews undertaken for accepted manuscripts. Reviewers are asked to complete a checklist review form ([see an example](#)) and are provided with free text boxes to elaborate on their assessment. These free text comments are reproduced below. Some articles will have been accepted based in part or entirely on reviews undertaken for other BMJ Group journals. These will be reproduced where possible.

ARTICLE DETAILS

TITLE (PROVISIONAL)	Home-based cardiac rehabilitation is an attractive alternative to no cardiac rehabilitation for elderly patients with coronary heart disease. Results from a randomised clinical trial.
AUTHORS	Oerkild, Bodil; Frederiksen, Marianne; Hansen, Jørgen; prescott, eva

VERSION 1 - REVIEW

REVIEWER	Dr H M Dalal Hon Clinical Senior Lecturer Peninsula Medical School Research & Development Knowledge Spa Royal Cornwall Hospitals Trust Truro TR1 3HD
REVIEW RETURNED	13-Sep-2012

THE STUDY	This paper is based on a study conducted by the lead author and others that was first published electronically on 15 September 2010 [Oerkild, B., et al. "Home-based cardiac rehabilitation is as effective as centre-based cardiac rehabilitation among elderly with coronary heart disease: results from a randomised clinical trial." <i>Age Ageing</i> 40.1 (2011): 78-85]. Surprisingly no direct reference is made to the original paper! The methods section of both papers cite exactly the same local ethics committee, Danish Data Protection agency and clinical trial registration reference numbers. Even the text in certain sections of both papers is identical. It seems that the overall study design was for a comparison of home-based cardiac rehabilitation versus centre-based cardiac rehabilitation. Given the small sample size (n=40) and no mention of a power calculation in the methods section makes the overall study design inadequate to answer the research question. Even sections describing the statistical analysis have been copied verbatim from the original paper published in 2010.
RESULTS & CONCLUSIONS	It is difficult to see how the authors could have hoped to achieve anything significant with an intervention involving just two visits and one telephone call from a physiotherapist in only 19 'intervention' patients. One possible message is that the intensity rehabilitation must be adequate if long term improvement is the goal. The authors don't really make that point at all well, and in general the discussion section is weak. For example, they state that 'The study confirms that elderly patients who decline participation in centre-based CR are a very fragile group with low level of exercise capacity..' There

	<p>is no justification for this. What is the exercise capacity of 'normal' people in this age group? The discussion could have made reference to the correspondence in 'Heart' following RISK, about the importance of a well structured and well supported rehab programme in to maintain long term benefit in terms of exercise capacity and quality of life. Ideas on how to sustain the the short term benefits of rehab would be helpful.</p> <p>Other points: The recruitment methods are not fully described as in the original 2010 publication by the authors. The poor health related quality of life [HRQoL]outcomes should be compared with other studies and discussed. What were the possible reasons for the lack of improvement in HRQoL? Was it due to the low level of support provided?</p> <p>All in all there is little that this paper adds to that published by the same authors in 2010.It may be more acceptable if recruitment was explained in more detail and the various inaccuracies in the text were corrected - and the point about proper rehab was more forcefully made.</p>
GENERAL COMMENTS	<p>Given my initial reservations about this paper I took the liberty of sharing the manuscript confidentially with Dr Tony Mourant, a retired consultant cardiologist. we have worked together for many years. With his permission I have included some of his comments in the sections above.</p>

REVIEWER	Taylor, Rod Peninsula Medical School, Universities of Exeter and Plymouth
REVIEW RETURNED	18-Sep-2012

GENERAL COMMENTS	<p>This paper describes a randomised controlled trial comparing receivership of an exercise-based cardiac rehabilitation home programme with no cardiac rehabilitation provision in an elderly population. As the authors note there is little evidence of the impact of home-based rehabilitation provision in older individuals so this study therefore provides a potential useful contribution to the body of knowledge in this area.</p> <p>In general the study appears to have been well conducted and is reasonably well reported. However, there are some specific issues that require response and revision before the paper to be acceptable. I have highlighted by section below. It was unclear if the reporting currently conforms to CONSORT guidelines. This should be checked and statement to this effect added at the outset of the methods section.</p> <p>Abstract Objective – to “compare” home-based....; clarify the term ‘usual care’ in many setting, including some parts of UK, usual care post event would include cardiac rehabilitation. Suggest rephrase as non-rehabilitation control or equivalent. Design – and mortality follow up of 5.5 years. State if follow up is mean or median. Results –should the 12-month reported 6MWT differences not be negative? Conclusions – too positive in tone. Needs to be reworded according to the observed data i.e. there no was statistically significant difference between intervention and control in primary and</p>
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secondary outcomes; “65 or more” years

Introduction

Pg 3 line 36 ‘this group may benefit the most’ This statement is speculative and should be dropped.

Pg 3 line 43 rephrase sentence ‘In order to improve access and, therefore, participation rate, there has....’

Pg 3 line 49 ref 9 – an updated systematic review has been published since the Jolly review – see Dalal H, Zawada A, Jolly K, Moxham T, Taylor RS. Home based versus centre based cardiac rehabilitation: Cochrane systematic review and meta-analysis. Brit Med J 2010;340:b5631.

Pg 3 line 52 ‘at some points’ – unclear. Reword.

Methods

P4 line 29. Define ‘new’

P4 line 52 ‘The result of the randomisation....’. Sentence needs to be reworded.

Statistical analysis: Not appropriate to statistically compare baseline data between groups in an RCT; The authors have reported baseline-follow up differences that are subject to regression to the mean. It was unclear if these differences were adjusted for baseline outcome values; Statement on how missing data was handled should be added and clarify imputation methods used.

Results

Table 2. reconsider current subheadings e.g. HADS is not a quality of life measure; include P-values in addition to 95% CIs. Suggest table 2 represented to give absolute outcome for 2 groups at 3-months and the 3 month between group difference (mean, 95% CI and P-value), preferably based on ANCOVA - see earlier comment.

Table 3. The comparison of 3 vs 12 months while not technically wrong is not intuitive. What policy makers/readers what to know is whether outcomes at 12 months at different between the two groups. Suggest that the authors combine table 2 and 3. In addition to above reformatted table add the absolute outcomes in both group at 12-months and between group difference at 12 months.

Pg 12 line 14. Rephrase sentence to ‘Nine patients died....’

Discussion

Pg 12 line 28 ‘fragile group with low level of exercise capacity’. It is unclear how the authors have arrived at this statement. Should be substantiated by data or dropped

Pg 12 line 22 ‘Results from these programmes are promising’.

Evidence for the heart manual is now well supported – see systematic review of heart manual evidence by Clark Eur J Cardiovasc Nursing 2010

Pg line 25. Agree that trial sample size may be a limitation. The authors should indicate if they based their trial sample size target on a formal sample size calculation.

Conclusions

As stated above, the authors conclusions need to redrafted to more accurately reflect the findings of the study findings.

VERSION 1 – AUTHOR RESPONSE

Reviewer: Dr H M Dalal
Hon Clinical Senior Lecturer
Peninsula Medical School
Research & Development
Knowledge Spa
Royal Cornwall Hospitals Trust

This paper is based on a study conducted by the lead author and others that was first published electronically on 15 September 2010 [Oerkild, B., et al. "Home-based cardiac rehabilitation is as effective as centre-based cardiac rehabilitation among elderly with coronary heart disease: results from a randomised clinical trial." *Age Ageing* 40.1 (2011): 78-85]. Surprisingly no direct reference is made to the original paper! The methods section of both papers cite exactly the same local ethics committee, Danish Data Protection agency and clinical trial registration reference numbers. Even the text in certain sections of both papers is identical. It seems that the overall study design was for a comparison of home-based cardiac rehabilitation versus centre-based cardiac rehabilitation. Given the small sample size (n=40) and no mention of a power calculation in the methods section makes the overall study design inadequate to answer the research question. Even sections describing the statistical analysis have been copied verbatim from the original paper published in 2010.

COMMENTS: Please see the answer above to managing editor and editor-in-chief. The manuscript has now been changed according to your suggestions and should now be more precise. In addition, please see the answer to Dr. Taylor concerning sample size calculation.

It is important to emphasize that this study does NOT compare home-based cardiac rehabilitation with centre-based cardiac rehabilitation. The study compares home-based cardiac rehabilitation with usual care, which was no rehabilitation in this case.

It is difficult to see how the authors could have hoped to achieve anything significant with an intervention involving just two visits and one telephone call from a physiotherapist in only 19 'intervention' patients.

COMMENTS: We agree with Dr. Dalal, that the size of the study is small, why this is also the first limitation mentioned in the discussion: "The main limitation of this study is the number of patients included...".

However, small study size is often the case in exercise trials especially in single-centre exercise trials. In addition, exercise trials with a randomised design are frequently small because of the extensive intervention needed to complete these types of studies. In the latest Cochrane review comparing home-based cardiac rehabilitation versus centre-based cardiac rehabilitation (Taylor et al, June 2010) 25% of the included studies had fewer patients than our study and in a review comparing (comprehensive) home-based cardiac rehabilitation with usual care (Jolly et al *Int.J.Cardiol.* 2006;111:343-51) 2 of 9 studies had the same size as in our study. Further, this study differs from previous studies in that it only includes patients who declined participation in centre-based rehabilitation. In the revised paper we have specified this both in the Methods section and in the Discussion.

Our intervention involving two visits and a telephone call from a physiotherapist, contact with a cardiologist, dietary counselling and (if needed) smoking cessation is not inferior to other home-based exercise trials, and may even be more intensive (Cochrane review, home-based versus centre-based cardiac rehabilitation, Taylor et al, June 2010).

We agree with the reviewer, that a more intensive intervention would significantly have increased the probability for a more positive outcome. However, our home-intervention is designed as a real life scenario intervention that should have the potential to become a permanent integrated part of our rehabilitation unit.

In the revised paper, we have specified: "..... the duration and intervention of our programme is in line

with other home-based programmes”.

One possible message is that the intensity rehabilitation must be adequate if long term improvement is the goal. The authors don't really make that point at all well, and in general the discussion section is weak. For example, they state that ' The study confirms that elderly patients who decline participation in centre-based CR are a very fragile group with low level of exercise capacity.. ' There is no justification for this. What is the exercise capacity of 'normal' people in this age group? The discussion could have made reference to the correspondence in 'Heart' following RISK, about the importance of a well structured and well supported rehab programme in to maintain long term benefit in terms of exercise capacity and quality of life. Ideas on how to sustain the the short term benefits of rehab would be helpful.

COMMENTS: We thank for the comments and do agree. The discussion is now significantly changed according to your suggestions.

In the revised paper we have discussed the low level of exercise capacity in our population with the results in a normal population and with the results obtained in our study comparing home-based CR with centre-based CR (Age Ageing 40.1 (2011): 78-85). We have also as suggested, discussed and emphasized that our home programme may have been too short to maintain changes in lifestyle at 12 months follow-up.

In addition, we have discussed the problems on how to maintain long term benefits of cardiac rehabilitation.

For further detail please see the Discussion.

Other points:

The recruitment methods are not fully described as in the original 2010 publication by the authors.

COMMENTS: We agree with the reviewer that the recruitment methods are not fully described which has been changed in the revised paper:

“Patients were recruited from our Rehabilitation Unit which offers centre-based CR to all patients with coronary heart disease assigned to the hospital. In order to ensure that all patients receive the CR treatment offer, the referral procedure is centralized and computerized with identification of patients from a database covering diagnosis and all invasive procedures performed in the catchments area of Bispebjerg University Hospital, Copenhagen. Patients are consecutively invited by letter and non-responders are additionally contacted by telephone. At the first visit in the Rehabilitation Unit patients were invited to participate in the previous mentioned RCT comparing home-based CR with centre-based CR 6, or as an alternative encouraged to participate in the centre-based CR programme (outside the study). Patients who declined participation in these offers were invited to participate in this study”.

The poor health related quality of life [HRQoL] outcomes should be compared with other studies and discussed. What were the possible reasons for the lack of improvement in HRQoL? Was it due to the low level of support provided?

COMMENTS: In the revised paper we have now added:

“We did not find any significant changes in HRQoL measured by SF-12. This is partly due to lack of statistical power and the limited duration of our home intervention but is in concordance with the meta-analysis by Jolly et al 13 and with a recent published review concerning CR and HRQoL 36. We did not have any specific psychological intervention but the type of intervention (comprehensive programmes, exercise only or mainly psychological interventions) do not seem to affect these results 13;36 ”.

All in all there is little that this paper adds to that published by the same authors in 2010. It may be more acceptable if recruitment was explained in more detail and the various inaccuracies in the text were corrected - and the point about proper rehab was more forcefully made.

COMMENTS: One of the main problems in centre-based cardiac rehabilitation is the low participation

rate among patients in general and among elderly patients in particular. Participation rates are reported to be as low as 30% of eligible patients (Jackson et al, Heart 2005;91:10-14) but among elderly patients participation rate is estimated to be even lower (ex. Pasquali et al Am.Heart J. 2001;142:748-55). In addition, adherence rate to the centre-based programs are low and drop-out rates are high (ex. Worcester et al, Eur.J.Cardiovasc.Prev.Rehabil. 2004;11:328-35). In order to optimize the secondary treatment of patients with coronary heart disease it is necessary to further develop the rehabilitation programmes. Several guidelines have advocated for home-based cardiac rehabilitation (Giannuzzi et al Eur.Heart J 2003;24:1273-8 and Graham et al Eur.J Cardiovasc.Prev.Rehabil.2007;14 Suppl 2:s1-113 and Thomas et al J.Am.Coll.Cardiol.2007;50:1400-33) and these programmes are now the main alternative to centre-based programmes. However, still little is known about the effect and even less is known of the effect among the elderly.

In the latest Cochrane review comparing home-based cardiac rehabilitation versus centre-based cardiac rehabilitation (Taylor et al, June 2010) the total number of RCTs included were only 12 studies. The mean ages of the study population were 52-69 years and only one study included the old/very old patients (Marchionni et al Circulation 2003;107:2201-6). In the present study mean age is 76 years.

A review from 2005 found only 9 trials comparing comprehensive home-based rehabilitation with usual care and again the only study including old and very patients were Marchionni (Marchionni et al Circulation 2003;107:2201-6).

A major concern in previous meta-analyses and reviews on home-based rehabilitation is that the included populations in the studies are highly selected, with exclusion of elderly patients and patients with heart failure and co-morbidity. In the Cochrane review it is stated in the conclusion: "that the populations may not be generalisable to the wider community of cardiac patients".

Our population did include elderly cardiac patients with co-morbidity.

In UK and Ireland approximately 20% of the home-based rehabilitation programs are delivered through the use of The Heart Manual (Cochrane review, home-based versus centre-based cardiac rehabilitation, Taylor et al, June 2010), who often have less formalised intervention than in our study. The Heart Manual is currently not an alternative in other countries, and other programs are thus needed to be developed.

Based on the above comments and the actual paper, we are convinced, that the revised paper contributes to the scientific gap on how to manage the increasing population of elderly patients with coronary heart disease who are not interested in (or cable of) participating in a centre-based rehabilitation programme. In addition, we believe that our population represents the everyday population of elderly cardiac patients with coronary heart disease seen at the rehabilitation units.

Given my initial reservations about this paper I took the liberty of sharing the manuscript confidentially with Dr Tony Mourant, a retired consultant cardiologist. we have worked together for many years.

With his permission I have included some of his comments in the sections above.

COMMENTS: We are grateful and honored for Dr. Dalal's sharing of our manuscript with Dr. Mourant in order to optimize the manuscript.

Reviewer: Rod Taylor

Peninsula Medical School, Universities of Exeter and Plymouth

This paper describes a randomised controlled trial comparing receipt of an exercise-based cardiac rehabilitation home programme with no cardiac rehabilitation provision in an elderly population. As the authors note there is little evidence of the impact of home-based rehabilitation provision in older individuals so this study therefore provides a potential useful contribution to the body of knowledge in this area.

In general the study appears to have been well conducted and is reasonably well reported. However, there are some specific issues that require response and revision before the paper to be acceptable. I have highlighted by section below. It was unclear if the reporting currently conforms to CONSORT guidelines. This should be checked and statement to this effect added at the outset of the methods section.

Comments: With the submitted paper is a completed CONSORT 2010 checklist with references to the manuscript.

Abstract

Objective – to “compare” home-based....; clarify the term ‘usual care’ in many setting, including some parts of UK, usual care post event would include cardiac rehabilitation. Suggest rephrase as non-rehabilitation control or equivalent.

COMMENTS: We agree that the term “usual care” may be ambiguous. This have now been clarified by adding in the abstract:.....usual care (control group with no-rehabilitation). This is also clarified in the Method section.

Design – and mortality follow up of 5.5 years. State if follow up is mean or median.

COMMENTS: Mortality data was collected 5½ years after the study began. The mean follow-up time was 4½ year, this is now added in both the abstract and in the Results.

Results –should the 12-month reported 6MWT differences not be negative?

COMMENTS: The 12-month reported 6MWT differences are now changed to a negative result in both the Abstract and the Results. This was not included initial because “...decline in 6MWT of” was the sentence.

Conclusions – too positive in tone. Needs to be reworded according to the observed data i.e. there no was statistically significant difference between intervention and control in primary and secondary outcomes; “65 or more” years

COMMENTS: As the reviewer suggested, the conclusion has been modified in both Abstract, Discussion and Results: “Participation in home-based CR improved exercise capacity among elderly patients with coronary heart disease, but there was no significant difference between the home intervention and the control group. In addition, no significant difference was found in the secondary outcomes. When intervention ceased the initial increase in exercise capacity was rapidly lost”.

Introduction

Pg 3 line 36 ‘this group may benefit the most’ This statement is speculative and should be dropped.

COMMENTS: The statement has been dropped as suggested.

Pg 3 line 43 rephrase sentence ‘In order to improve access and, therefore, participation rate, there has....’

COMMENTS: The sentence has been rephrased.

Pg 3 line 49 ref 9 – an updated systematic review has been published since the Jolly review – see Dalal H, Zawada A, Jolly K, Moxham T, Taylor RS. Home based versus centre based cardiac rehabilitation: Cochrane systematic review and meta-analysis. Brit Med J 2010;340:b5631.

COMMENTS:

We have read the publication by Dalal, Taylor et al in BMJ 2010. The systematic review compares home-based rehabilitation versus centre-based rehabilitation but does not compare home-base rehabilitation versus usual care (no intervention), which is the objective in this study. The only review we are aware of that compares home-based rehabilitation with usual care is the review by Kate Jolly from 2006. If we are uninformed of any other recent papers, please let us know.

Pg 3 line 52 'at some points' – unclear. Reword.

COMMENTS: We agree that “at some point” is unclear and to be shortened. It is therefore changed to: “A review from 2006 comparing home-based programmes with usual care (no rehabilitation) found a significantly better outcome in systolic blood pressure and in the likelihood of being a smoker. In addition, the home-based programmes had better outcomes with regard to exercise capacity, total cholesterol, anxiety and depression score although these data did not reach statistical significance”.

Methods

P4 line 29. Define 'new'

COMMENTS: “New” refers to patients who just have had a coronary event. The referral procedure is computerized at our Rehabilitation Unit and thus independent of doctor referral from the Coronary Department and from the Department of Cardiothoracic Surgery. This centralized procedure is established because several publications have found a significant referral bias to cardiac rehabilitation when performed by physicians.

We agree that “new” can be misunderstood. It is changed in the revised paper, and is hopefully now more precise: “Inclusion criteria were patients > 65 years with a recent coronary event defined as....”

P4 line 52 'The result of the randomisation....'. Sentence needs to be reworded.

COMMENTS: The sentence has been reworded: “Due to the nature of the intervention concealment of randomisation was not feasible with regard to both patients and researcher”.

Statistical analysis: Not appropriate to statistically compare baseline data between groups in an RCT; The authors have reported baseline-follow up differences that are subject to regression to the mean. It was unclear if these differences were adjusted for baseline outcome values;

COMMENTS: According to the recent CONSORT STATEMENT (2010): “Baseline information is most efficiently presented in a table” and “Tests of baseline differences are not necessarily wrong, just illogical.” (http://www.consort-statement.org/consort-statement/13-19---results/item15_baseline-data/).

Our baseline characteristics are presented as proposed by the CONSORT STATEMENT. As suggested by the reviewer we have excluded the significance tests.

The sections with statistical analysis and results have been changed as suggested.

Statement on how missing data was handled should be added and clarify imputation methods used.

COMMENTS: Great effort was made to collect data in order to reduce missing data.

However, if a dataset was missing the patients would still contribute with available data in the analysis (e.g. a patient who died before collection of endpoints at 12 months would still contribute with data at baseline, 3 and 6 months in the analyses).

No imputation was performed.

Results

Table 2. reconsider current subheadings e.g. HADS is not a quality of life measure;

COMMENTS: Subheadings has been changed as suggested to: “health related quality of life (HRQoL), anxiety and depression” in both table 2 and table 3.

include P-values in addition to 95% CIs.

COMMENTS: It is mentioned in the CONSORT STATEMENT 2010: “For all outcomes, authors should provide a confidence interval to indicate the precision (uncertainty) of the estimate. A 95% confidence interval is conventional, but occasionally other levels are used”. Later it is stated: “Although P values may be provided in addition to confidence intervals, results should not be reported solely as P values.” (http://www.consort-statement.org/consort-statement/13-19---results/item17a_outcomes-and-estimation/)

In concordance with the CONSORT STATEMENT 2010 we do not believe that adding p-values to the

95% CI will give further information to the reader, but will instead interfere with the overview of table 2 and 3. We hope the reviewer agrees and finds our point of view acceptable.

Suggest table 2 represented to give absolute outcome for 2 groups at 3-months and the 3 month between group difference (mean, 95% CI and P-value), preferably based on ANCOVA - see earlier comment.

Table 3. The comparison of 3 vs 12 months while not technically wrong is not intuitive. What policy makers/readers what to know is whether outcomes at 12 months at different between the two groups. Suggest that the authors combine table 2 and 3. In addition to above reformatted table add the absolute outcomes in both group at 12-months and between group differences at 12 months.

COMMENTS: We have tried to change the table in different ways e.g. give the absolute outcomes for the two groups at both 3 and 12 months as suggested by the reviewer. However, since this paper focus on changes in outcomes in the intervention period (baseline to 3 months) and the follow-up period (3 months to 12 months) it is more logic for the reader if data are presented as differences. For comparison the very large HF-ACTION trial also presented their results as differences (O'Connor CM et al. HF-ACTION trial. JAMA 2009; 301(14):1439-1450.).

In addition, we have also tried to combine table 2 and table 3 which lead to an impaired overview. We hope the reviewer accept the presentation of data.

We used a mixed model in order to analyse the effect of the interventions, since this statistical model allow us to include all data (i.e., in our study data from baseline, 3, 6, and 12 months) into one analysis. The ANCOVA may be regarded as a model nested in the mixed model used. Thus, the mixed model is an extension of the ANCOVA.

Pg 12 line 14. Rephrase sentence to 'Nine patients died...'

COMMENTS: The sentence has been rephrased to: "A total of nine patients died during a mean follow-up of 4½ years".

Discussion

Pg 12 line 28 'fragile group with low level of exercise capacity'. It is unclear how the authors have arrived at this statement. Should be substantiated by data or dropped

COMMENTS: As suggested we have removed "fragile" from the paper.

Pg 12 line 22 'Results from these programmes are promising'. Evidence for the heart manual is now well supported – see systematic review of heart manual evidence by Clark Eur J Cardiovasc Nursing 2010 Pg line 25.

COMMENT: We thank the reviewer for drawing our attention to this study and have omitted the sentence. However, it is important to emphasize, that the majority of evidence for The Heart Manual (and home-based cardiac rehabilitation) primarily come from the same scientific group. This could be a problem in the generalization of the findings.

Agree that trial sample size may be a limitation. The authors should indicate if they based their trial sample size target on a formal sample size calculation.

COMMENTS: Patients inclusion was not based on a sample size calculation. Our previous published RCT study comparing home-based rehabilitation with centre-based rehabilitation (Age Ageing 40.1 (2011): 78-85) was based on a sample size calculation. Since the current study included patients who declined participation in that RCT study and in addition declined participation in the formal centre-based programme (outside any study), the eligible population for this study is small.

However, as outlined above to Dr. Dalal the study size is comparable with previous studies.

Added in the paper is: "Inclusion of patients was not based on a sample size calculation".

Conclusions

As stated above, the authors conclusions need to redrafted to more accurately reflect the findings of the study findings.

COMMENTS: As suggested, the conclusion has been redrafted and modified as suggested: "In this study of patient > 65 years with coronary heart disease home-based CR improved exercise capacity, but there was no significant difference between the home intervention and the control group. In addition, no significant difference was found in the secondary outcomes. The study found that elderly cardiac patients who declined participation in centre-based CR had low exercise capacity and high level of co-morbidity and disability. These characteristics indicate that results from exercise trials excluding this group of patients should be cautiously applied to the elderly population. After cessation of the home intervention the gained improvement in exercise capacity was rapidly lost. This emphasises, that close follow-up with continuous guidance beyond the initial rehabilitation period is important. This study could contributes to the scientific gap on how to manage the large population of elderly cardiac patients who are not interested in (or cable of) participating in a centre-based CR programme. Larger trials of unselected older patients are needed in order to confirm our findings".

VERSION 2 – REVIEW

REVIEWER	Professor Rod Taylor Professor in Health Services Research Peninsula College of Medicine & Dentistry Exeter, UK
REVIEW RETURNED	19-Nov-2012
GENERAL COMMENTS	The authors are to be commended on their comprehensive revisions. The paper will make an excellent contribution to the literature.